UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF WISCONSIN

GREGORY BOYER, as Administrator
of the Estate of Christine Boyer,
and on his own behalf,

Plaintiff,

vs. Lead Case No. 20-CV-1123

ADVANCED CORRECTIONAL
HEALTHCARE, INC., et al.,

Defendants.

GREGORY BOYER, as Administrator
of the Estate of Christine Boyer,
and on his own behalf,

Plaintiff,

vs. Case No. 22-CV-723

USA MEDICAL & PSYCHOLOGICAL
STAFFING, et al.,

Defendants.

Remote Zoom Deposition of HOMER D. VENTERS, M.D.

Witness Location: Port Washington, New York

Thursday, January 9, 2025

9:02 a.m. to 3:52 p.m.

with all parties appearing via Zoom Videoconference

Job No. 179598
Stenographically Reported by
Julie A. Poenitsch, RPR/RDR/CRC/CRR

Remote Zoom Deposition of HOMER D. VENTERS, M.D., a witness in the above-entitled action, was taken at the instance of the Defendants, under and pursuant to the Federal Rules of Civil Procedure, and pursuant to Notice, before me, JULIE A. POENITSCH, RPR/RDR/CRC, Certified Realtime Reporter, and Notary Public in and for the State of Wisconsin, with all parties appearing via Zoom Videoconference, on the 9th day of January, 2025, commencing at 9:02 a.m. and concluding at 3:52 p.m.

APPEARANCES

LOEVY & LOEVY, by
Ms. Maria Makar
311 North Aberdeen Street, Suite 3
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appeared via videoconference on behalf of the Plaintiff.

LEIB KNOTT GAYNOR LLC, by
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appeared via videoconference on behalf of the Defendants ACH, Lisa Pisney, and Amber Fennigkoh.

APPEARANCES CONTINUED

GERAGHTY, O'LOUGHLIN & KENNEY, P.A., by
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appeared via videoconference on behalf of the Defendants USA Medical & Psychological Staffing, Jillian Bresnahan, Norman Johnson, Travis Schamber, and Wesley Harmston.

HANSEN REYNOLDS LLC, by
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appeared via videoconference on behalf of the Defendants Monroe County Sheriff's Office, Stan Hendrickson, Danielle Warren, and Shasta Parker.

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EXHIBITS

(The original exhibits were attached to original transcript; electronic copies provided with transcript copies.)

REQUESTS

TRANSCRIPT OF PROCEEDINGS

HOMER D. VENTERS, M.D., called as a witness herein by the Defendants, after having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. KNOTT:

Q Good morning, sir. Could you please state your full name for the record?

A Homer Venters.

Q And you're a medical doctor; is that true?

A Yes.

Q And my understanding is you've given depositions in the past.

A Yes.

Q Approximately how many depositions, where you're sworn and have a court reporter in the room, do you think you've given?

A I would guess between 20 and 30, but I'm not positive.

Q And I was trying to exclude from that testimony in hearings or proceedings other than sort of litigation. Did I stumble on the right question there for you to answer that?

A Yes. Most of my work now is -- doesn't involve

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depositions, it involves hearings as a monitor, so that 20 to 30 is my estimate of the depositions.

Q And that would be in legal proceedings, like a courtroom, personal injury proceedings?

A I don't know about the personal injury component of it, but all my work is correctional health, so both the individual case litigation and now most of my work as a medical monitor, which involves testimony in front of courts, it's all correctional health, one way or the other.

Q And at the end of your -- at the end of your curriculum vitae, there is a list of prior testimony and depositions. The first entry is in 2015.

Were there -- I think you testified in legal cases before then?

A No, I don't believe so.

Q Okay. And all of that was to get to the point that you're familiar with the process and kind of understand that we shouldn't speak over one another. I'll try to do my best on that. If you could do your best as well, I'd appreciate it.

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A Yes.

Q And you're entitled to have a question that you heard and understand, and if you would like clarification or me to rephrase the question in any way, please speak up, and I'll do so, okay?

A Okay.

Q If you proceed to answer the question, I, and anybody who reads the transcript, is going to assume that you understood the question. Is that fair?

A Yes.

Q We're here to discuss your opinions in the matter involving Christine Boyer and the Monroe County Jail. You understand that?

A Yes.

Q And I've received a transcript -- or excuse me, I've received your report. Does that accurately and completely summarize your opinions in the matter?

A Yes, based on the information I've reviewed up to this point.

Q And the report, I think, is dated November 26 of 2024. Do you know if you've reviewed anything since that time relevant to the case?

A No, I don't believe so.

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Q So the report is a summary of your final opinions, and you're prepared to discuss them today.

A Yes. Just with a qualification I said that if there was different information or other information, it could change my opinions, but certainly the report reflects my opinions as I sit here today.

MR. KNOTT: Ms. -- I think it's -- Maria, how do you pronounce your name? Makar?

MS. MAKAR: Makar.

MR. KNOTT: Say it again.

MS. MAKAR: Makar, like driving in my car.

BY MR. KNOTT:

Q Dr. Venters, you met with Ms. Makar to prepare for the deposition, I assume.

A Yes.

Q Can you tell me when you met with her to discuss the deposition?

A Yesterday.

Q And was that via Zoom?

A Yes.

Q Did any other people other than you and Ms. Makar participate in the Zoom conference?

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A I don't believe so.

Q Were you shown anything during your conference with Ms. Makar yesterday?

A No.

Q In your report you state that your role is to assess the adequacy of the care provided to Ms. Boyer in the time she was detained and leading up to the time of her death.

Is that what you understand your role in the matter to be?

A Yes.

Q Were you assessed to -- were you asked to assess the adequacy of anyone else's care other than Ms. Boyer?

A I was provided with additional records. There are other people referenced in the report, and so I did review other people's records to see if any of the deficiencies or problems I found with Ms. Boyer's care were present for those other people.

Q Is it your understanding that you received complete medical files for inmates other than -- excuse me, detainees other than Ms. Boyer?

A No. I think I explicitly say in my report that

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the additional patients, the information I reviewed, was quite varied and incomplete. Sometimes it involved medical records; sometimes it didn't. So I think, as I say in my report, it's not my position or understanding that I have all the possible records for those people.

Q Are all of the detainee patients about whom you have formed opinions named in your report?

A I don't think I have any opinions about anybody that's not in the report. So I think that's -- I'm answering yes to your question, I believe. There's no person that I've formed opinions about besides the people whose records I was provided.

Q And were you provided records for detainee patients other than those that you've named in the report?

A Yes. I believe I -- it would be helpful for me to look at this section of the report, because I'm quite clear with the language I use, but I believe I was presented with maybe 25 or 26 files, but some of them were quite incomplete or didn't involve, for instance, anything except an autopsy report, or something like

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that.

And so I looked at all of those 26 files, and based on what was in those files, I assessed whether or not any of the core problems or findings that were present in Ms. Boyer's case were apparent in these other cases.

And so as I say in my report, many of these files were just incomplete or I couldn't form an opinion.

Q Were there any files that you looked at and concluded that the care was adequate?

MS. MAKAR: Objection. Form.

THE WITNESS: I don't recall. I think I was going through with these, really, three things in mind and -- I don't recall as I sit here today.

BY MR. KNOTT:

Q Were you -- well, were you provided any lists of detainees whose files you would be reviewing?

A No. I received a large collection of files. So it was a big collection of 25 or 26 people's names, and each one had an individual file. And so I opened each of those up to look and

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see what was available. And as I say in the report, and I just said here, in some of those cases, I was able to discern some of the problems that I saw in Ms. Boyer's case.

Q In any of those matters that you looked at, did you locate a COWS or CIWA standardized withdrawal monitoring tool?

A I --

MS. MAKAR: Objection. Outside the scope. Work product privilege.

THE WITNESS: I don't recall.

BY MR. KNOTT:

Q And so you were -- we sent out a Notice Duces Tecum asking you to bring certain things to the deposition. Have you had an opportunity to review that?

A Yes.

Q And is there anything that you brought with you to the deposition responsive to the duces tecum?

A No.

Q And why is that?

A I believe everything that's requested either is in my report, or my practice is also, with counsel, to have them send, for instance, an

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invoice to you, since they have that.

But I didn't see anything listed that was additional that wasn't either information that counsel provided to me or I had already sent to counsel so that they could provide that to you.

MR. KNOTT: Maria, do you have an invoice for Dr. Venters?

MS. MAKAR: I'll check. I believe so.

BY MR. KNOTT:

Q The request in the duces tecum was for an itemization of the hours spent and compensation to be paid for the witness's review and testimony in the case.

Dr. Venters, does your invoice itemize the hours spent and compensation you've been paid?

A Yes.

Q I'd like that to be provided, please.

Dr. Venters, do you, in the course of your preparation of your report, take notes on the files that you review?

A The notes that I take are in a Word document that ultimately becomes the report itself, and

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so my approach is to create a timeline of medical events and then build the report from there. I don't have a separate set of notes, a separate set of recordings or notes other than the report.

Q So your testimony is that as you sit here today, the only thing you could put your hands on, in terms of work product for the work that you've done on this matter, is the report dated November 26, 2024?

A Yes.

Q You said that you -- your process is to build a timeline. Did you do that in this case?

A Yes. There's a report -- part of the report where I review the medical records of the patient, in this case Ms. Boyer, and that would have been the first thing I would write in this document, and then I would go from there.

Q So there's a narrative description of the care. There is nothing I would describe as a timeline. Are you saying that you did not do a timeline in this case?

A Since you're asking me about my report, can I look at it?

Q Absolutely.

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A Okay. At the bottom of page 4, Section III is entitled "Timeline of Events."

Q And that's the reference to the timeline that you just made.

A Yes.

Q Okay. And I want to ask you more about how you received patient files.

In referencing page 4, your list of materials reviewed includes as the fourth bullet point on page 4 patient files from the subpoena, and it says, for 26 ACH patients outside Monroe County Jail. And that's 4,228 pages.

Did you receive all 4,228 pages?

A I don't actually know as I sit here today. I received for each patient a file with their name on it, and I opened it up to look at medical records or to see what was there, with this lens that I already referenced, but I couldn't tell you right now as I sit here how many pages are in each of those.

Q And other than the -- so you received 26 individual files for those detainees, if I understand correctly.

A Yes.

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Q And did you receive any other kind of index or identifier for those 26 patients?

A Not that I recall.

Q Is your practice to highlight electronically or flag in any way the files that you receive?

A No.

Q Doctor, I think that the Bates number range -- and the reason I'm asking this question -- this Bates number range actually refers to more than 40 patient files. And my question is whether you reviewed 4,000 pages of records for more than 40 patients or whether the records that you reviewed were actually selected for you to review.

A My best answer is that -- and I just counted this the other day -- there's a file of additional cases. And I just looked at that file, and it had 26 names in it, 25 or 26 names, and so those are the files I opened.

I don't -- if there are -- I don't know if there are other cases, but those are the 26 that I received and that I looked at.

Q And how did you receive those records? Was it in a Dropbox-type link, or was it physically sent to you on a flash drive or something of

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that nature?

A No. I think everything I received in this case was through some sort of link, like a Dropbox or Box link.

Q I'm going to ask that you work with Ms. Makar to provide to us, via the same process, the materials that you reviewed in this case. Okay?

A Yes. That's not a problem, to work with her, since I would have received them from her, so yes.

MS. MAKAR: Doug, sorry to interrupt, but I just sent you the invoice. And you received the materials that we sent you along with Dr. Venters' report, correct?

MR. KNOTT: I'm sorry?

MS. MAKAR: You received the materials that we sent you along with Dr. Venters' report back in November, correct?

MR. KNOTT: I'm not sure what you're referring to. I have the CV and the report.

MS. MAKAR: There was also a Hightail link with all of the materials.

MR. KNOTT: Okay. Well, it's been a bit, so if that's there, I appreciate it; and

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if not, I'll work with you to try to make sure that I have those.

MS. MAKAR: That should have the invoice, too, but just in case it doesn't, I just re-sent it.

BY MR. KNOTT:

Q And, Dr. Venters, from our discussion so far, my understanding is that with respect to those other patient files, you do not receive any sort of abstract or summary or even a few word description of the issue of those cases; is that true?

A Not that I'm aware of. My process in this case was to look at this large file that had 26 names, to open each of those, and then to proceed as I have outlined in my report.

Q And appreciating that I may have received this information in November, but your report references medical records for Kenneth Wilson, Jennifer Lehman, and Larry Schmieder.

Do you know if you received and reviewed records for patients other than Boyer, the 26 patients referenced at bullet point four, and records for those three patients?

A I'm just consulting my -- page 4 of my report.

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No, I believe that that's the sum total of records that I reviewed, with the qualification that some of the 26 people, I think, might not have had actual medical records.

Q In that case, you received some jail-generated document pertaining to that patient, but you didn't receive medical records; is that fair?

MS. MAKAR: Objection. Form.

THE WITNESS: I think I even reference in my report, there was a patient for whom there was an autopsy report, but I don't think I saw any medical records.

So it was -- I was very careful in my report to say the type of information that I received for each person was quite variable, and so -- but in each case, there was a file with a person's name. I opened it up and reviewed what was there.

BY MR. KNOTT:

Q You are licensed in the state of New York, correct?

A Yes.

Q Do you hold a medical license in any other states?

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A No.

Q Do you currently have privileges at any health care facility?

A No.

Q How do you describe your current professional obligations?

A I work primarily as a federal monitor of health care in jail and prison settings, but I'm a correctional health physician.

Q Do you work through any kind of professional entity or corporation? Do you have a business that you -- that you contract through?

A No. I work as an independent contractor.

Q And so in addition to -- well, strike that.

You are not currently providing direct patient care in any capacity; is that true?

A That is true.

Q And your income is derived from being a monitor in certain cases, correct?

A Yes. It would be in some form of working in correctional health, either as a monitor, or I'm also retained by law enforcement agencies to investigate, so not as a monitor, but to help law enforcement investigate health care

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issues behind bars, but all of that is -- and then this type of litigation work, but that's all as a correctional health, I guess you could call it, consultant.

Q Are the instances in which you've been appointed as a monitor, an independent monitor for a correctional facility, are those all described in your curriculum vitae?

A I believe so, yes.

Q And then you said there are -- you consult with correctional facilities.

Do you have any current projects that you're working on, where you're consulting for correctional facilities?

A No. And I maybe wasn't clear. It's usually for a law enforcement agency. So the U.S. Department of Justice has retained me as an expert in their investigations of jail and prison health care for a number of years, and several state attorneys general have also retained me in the same manner.

Q And to the extent you've been retained by states' attorneys general, are those California, New York, and Illinois?

A Yes.

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Q Are those single projects for each of those states?

A In Illinois and California, yes, those were -- those are each single projects. And I'm not sure they're done, but I haven't done much recently.

In New York, I'm not currently working, but I have worked on, I think, maybe two jail investigations there.

Q And are those -- and I'm generalizing with respect to your retention by attorneys general -- are those investigations of incidents? Are they more broad investigations? Can you -- I'm trying to walk a line between not being too specific, but also wanting to know what you're doing.

A I would say for all of the law enforcement work, it's generally -- my role is generally to look at the adequacy of the health care, and sometimes that involves looking at a specific event, but it usually involves looking a little more broadly at some of the major elements of care, not just one incident.

Q Have the projects that you did for the states resulted in written reports that are publicly

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available?

A I don't believe so.

Q None of them have?

A Not that I'm aware of.

Q Can you tell me approximately what percentage of your income in the year 2023 was derived from consulting on legal cases for private litigants versus your work as a monitor and consultant?

A I don't know. I would guess 50/50, but I really don't know. I've never tallied that up.

Q And how about in 2024?

A Again, this is just a very gross estimate, but I would -- my estimate is that the monitoring would have been much more. Would have been probably 75 or 80 percent in 2024.

Q Was there a monitoring project in 2024 that absorbed more of your time?

A Well, I've added monitoring roles and decreased the amount of private litigation over the last several years. So one of the cases, I've been working on for maybe three or four years, but I've added subsequently other cases. So the monitoring has grown to take up most of my time.

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Q Do you know how the Loevy firm came to find you to ask that you consult on this case?

A I had worked with them on another case earlier in the year, but as to the question of how they came to contact me for that case, I don't know.

Q Do you recall the attorney you were working with at the Loevy firm on the other case?

A I worked both with Maria Makar, who's here on this case, and with another attorney, Steve Weil, I believe. And that's true for both -- that's true for the case in the prior engagement.

Q And do you know where that -- where the relevant care took place in the other matter on which you're consulting with the Loevy firm?

A State prison.

Q Which state?

A Illinois.

Q Have you issued a written report in that case?

A Yes.

Q And was your conclusion that the care did not meet standards?

MS. MAKAR: Objection. That's under protective order.

MR. KNOTT: I find that hard to

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believe, Maria.

MS. MAKAR: Why?

MR. KNOTT: His report, his conclusions are under a protective order?

MS. MAKAR: It hasn't been -- it's not on the docket yet. We haven't reached that point yet.

MR. KNOTT: Well, I wasn't really asking for the paper. I was asking whether he --

BY MR. KNOTT:

Q Well, Doctor, to the extent that you formed opinions in that matter, my understanding is they've been reduced to a report, right?

A Yes.

Q And as you sit here today, is it your recollection of that case that you believe that certain standards were not met with respect to the care of the Loevy client?

A As I sit here today, my report, to the best of my recollection, did include findings or opinions about deficiencies in care; but to specifically say what they were or which specific standards I was concerned with, I would need to consult a report.

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Q Do you recall the inmate's name in that case?
A No.
Q Have you given a deposition?
A Yes.
Q When did you give a deposition?
A Sometime last year. I don't -- it would have been in the second half of 2024 sometime.
Q And your report hasn't been filed?
A I don't know.
Q Do you remember the attorney who was in my role and was asking you questions in that matter?
A No.
Q Doctor, can you tell me how many matters in litigation or pre-litigation you have reviewed this year or worked on this year? I mean 2024.
A I -- no, I don't know.
Q Is there a typical caseload that you carry, in terms of matters in litigation?
A No.
Q You testified that you cut down on your -- on your litigation caseload. Do you know what the peak number of cases was before you cut down?
A If I said that -- I don't believe that's what I said. I said most of my work, the work I do now, is currently as a monitor. Many of the

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litigation cases might go on for years without me doing any work. So I don't keep track. I'm not sure if I would know how to keep track of when the cases resolve or are done.
The thing I am aware of is how much work do I do. And so the amount of work I do on the litigation side shrunk -- has shrunk over the last couple of years.
Q Doctor, do you have your CV with you, or do you have access to it?
A Yes, I can pull it up.
Okay. I think I have my most recent CV.
Q Is there some way, Doctor, for us to determine the date of the CV?
A I -- the CV I have is -- I think the file itself has a date of 5/2025. I'm just looking at the -- I'm trying to look at the actual document itself.
But May of 2025 is when I -- or of 2024, I apologize, is when I believe I last updated it.
Q And in the CV that you're looking at, is there a reference to the Illinois matter that you were retained by the Loevy firm?

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A No, I don't believe so.
Q And you've given a deposition like this one in that matter.
A Yes.
Q Is there a reason why it was not included in your prior testimony and deposition testimony that you provided to us?
A I don't think I've updated my CV since the first few months of 2024. So the hearings -- the court hearings as a monitor, and if there -- I think there might be one or two depositions, those wouldn't be on there yet. So I plan to update my CV in the coming month or two.
Q Can you give me all the information you can about the Illinois matter in which you've given a deposition that's not on your disclosure?
A Sorry. What do you -- what type of information are you -- you know.
Q You don't remember the patient -- the detainee/patient/plaintiff's name, correct?
A Yes, not as I sit here today.
Q Do you remember the defendant entity?
A I believe it was a for-profit prison vendor, and I think it may have been Wexford.

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Q And when did you give a deposition in that matter?
A Sometime in the --
MS. MAKAR: Object to form.
THE WITNESS: As I just said a couple minutes ago, I think in the second half of 2024.
BY MR. KNOTT:
Q Can you look on a calendar that's on the computer in front of you to tell us when you gave a deposition in that matter?
A I don't know if I would find it in my calendar as well as -- I could search through my email, if you want, while we're sitting here, to look and see.
Q Maybe we'll do that when we take a break. I'm going to make a note of it.
And can you tell me -- you said there were one or two cases that you've given depositions in that were not included on your list of prior testimony on your curriculum vitae.
Can you tell me anything about the other one or two cases, if there are two cases, in which you've given testimony that are not on

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your CV?
A No. I would need to go back and review my records to see what depositions have happened in the last eight months or so.
Q And there's been a single matter in which you've worked with attorneys from the Loevy firm, correct?
A Aside from this one, I believe that's correct.
Q Are you familiar with any of the attorneys other than Mr. Weil and Ms. Makar from the Loevy firm?
A Not that I'm aware of. It doesn't mean we couldn't have crossed paths, just not that I'm aware of.
Q From the list we were given, it looks to me like you've given approaching 30 depositions in matters in civil litigation. Does that many sound about right?
A As I said at the outset, my guess would be 20 to 30. But I haven't added them up, so I certainly wouldn't dispute that.
Q Have you ever given a deposition in a matter in which you testified on behalf of a defendant?
A I believe one of the first depositions listed, I wrote on my CV that I was representing the

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defendant, Benjamin v. Horn. I'm actually not sure legally what my title in the court was, but I was the medical director for the jail and was testifying about the adequacy of certain elements of care.
Q I've seen in prior testimony, you described that as acting as a fact witness. Is that what you were doing, to the best of your recollection?
A Well, that sounds like something a lawyer would say. I don't know if I ever -- but as I said, my -- I'll just repeat what I just told you, which is that I was the medical director at the time, testifying about the adequacy of the care. So however that's interpreted legally, I'm not going to dispute it. I'm just not -- that's kind of the end of my, like, understanding of the classification.
Q You were not a defendant in that case is my understanding.
A Correct.
Q But people that worked underneath you were defendants in that case; is that correct?
A No. I think it was that there was a court -- some legal process about whether previously

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agreed to or settled conditions were being met. And so I think Benjamin v. Horn, the case, was probably settled years before I became the medical director.
Q And other than that reference in your CV, you've never given testimony on behalf of a correctional facility or individual health care provider who is accused of providing inadequate care. Is that true?
MS. MAKAR: Objection. Form.
THE WITNESS: I think that's correct. I think -- yes, I think that's correct.
BY MR. KNOTT:
Q Have you told attorneys on the defense side that you don't want to do that type of work on the defense side?
A No.
Q Have you ever been retained to review a case on behalf of a facility or individual health care provider who is a defendant or potential defendant in litigation?
A Not that I'm aware of.
Q But you were never asked to review on behalf of the defendant?
A I've been asked by a correctional system to

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help them assess the adequacy of their care, but I don't think that was in relation to a specific case or a specific litigation area.
Q When were you last in a role where you were providing direct patient care?
A It would have been in -- when I was at Rikers. So I think I left in 2017, maybe. I would have to consult my CV. But my last direct patient care was there.
Q Are you board certified in any field?
A Yes. I have -- my internal medicine certification is through the NBPAS, the National Board of Physicians and Surgeons.
Q At one point you were certified by the American Board of Medical Specialties; is that true?
A No. I think I started with the ABIM, the American Board of Internal Medicine, and then I switched over to the NBPAS, probably with some overlap.
Q Is there a reason why you transitioned to that other -- the second organization?
A Yes. It seemed like people in medical administration, public health, it was a little bit better fit. So there was a couple-year period where I had both, and then I just stuck

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with the NBPAS since then.
Q The NBPAS does not require you to take exams in order to maintain your certification; is that true?
A That's right. It's continuing medical education.
Q And do you know how many hours per year you're required to take of continuing medical education to maintain your board certification with the NBPAS?
A I don't.
Q Do you know if the NBPAS requires a residency in internal medicine in order to obtain a certification in internal medicine?
A I assume so. I have a residency in internal medicine. I guess I assumed that, but I don't actually know as I sit here today.
Q Referencing your CV, Doctor, and the positions described under Independent Correctional Health Monitor, are each of the six positions listed under "Monitor" paid positions?
A Let's see. I am looking at them. Yes, although some of these were short term. Like, I think there's a date range in them. But I was paid for each of those and am paid for

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those in the cases that are ongoing.
Q And if I understand correctly, when you act as a monitor, you do not provide direct patient care.
A That's correct.
Q If I understand, a -- well, let me ask it fresh.
Do you have any ongoing projects with the United States Department of Justice?
A I believe so, yes.
Q And what generally are you doing for the U.S. DOJ?
A Helping them with assessing the adequacy of health care in a jail setting.
Q Are there particular jails you're looking at?
A I'm -- I believe I have an agreement of confidentiality with the Department of Justice, so I'm happy to consult with them after this and see if it's permissible, with that protective order, to disclose that to you.
Q Can I ask you, is it an investigation of an incident, or is it consulting on policy?
A I would say -- I don't -- all of the work I do with law enforcement involves adequacy of different types of care. And so usually that

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would involve more than just one incident.
Q Have you ever been asked to review care at a jail or prison in the state of Wisconsin?
A I -- not that I recall, as I sit here today.
Q And earlier you said that your last direct patient care was while you were at Rikers. Were you assigned to the infirmary at Rikers?
A No. My role at Rikers was to see patients. The only time I had a regular place that I provided care was when I first started, where there was one jail I would -- of the 15 jails, where I would see patients with residents; but then over time, I came to see patients for specific reasons, but I never had, besides that first year or so, an assigned place or time where I saw patients.
Q And that first year or so is when you were acting as Deputy Medical Director for Correctional Health Services, New York Department of Health and Mental Hygiene?
A Yes.
Q And what was the facility that you were assigned to?
A Well, I wasn't really assigned to it, but I had a regular time where I would try and at least

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have two days a week where I saw patients in what's known as the prison barge, but it's the letters VCBC, Vernon C. Baines, B-A-I-N-E-S. It's the floating jail off the -- in the Bronx.
Q And even as deputy medical director, you had just two clinical days a week?
A Yes.
Q So there was never a time when you were hired to staff a single facility full time, true?
A True.
Q Were you ever in a role as an on-call physician for a correctional facility?
A As a deputy medical director and medical director, I took calls. We did not have -- because we had a large system, we had people -- I didn't have an assigned duty as an on-call doctor, but I would regularly receive calls, while I wasn't working, about patient care.
Q And you said that you saw individual patients through your time as chief medical officer. What was the context in which you would see individual patients if you were not assigned a clinical day?
A It increasingly became patients that were either very sick or patients where there was

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use of force or there was some circumstance that required -- where the line staff required help.

Q And were you responsible in 2015 through 2017 for the supervision of the health care that was being provided at the Rikers facility?

A Yes. Rikers is an island that had most of the jails for New York City, but then in my role as medical director and then chief medical officer, that system is bigger than Rikers. It includes jails that are on Rikers Island and then three or four, depending on the year, jails in the boroughs off of the island.

Q And was there a hospital facility that was run by New York City for the jails?

A Not a hospital. We had an urgent care, which was a very limited place, on Rikers Island, where we could do basic emergency response if a patient was brought to us. But we never had a hospital in our system. We would send our patients to local hospitals, depending on the clinical status and other things.

Q And is it fair to say that the New York City jail facilities generally had infirmaries with inpatient or -- yeah, inpatient beds?

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A No. The use of the term "inpatient" has a very specific clinical threshold. And so I would say, in general, jail infirmaries are not inpatient beds by state definitions or Medicaid definitions. That was also -- that's true for the jail facility in New York City. There were two infirmaries, where patients who were below the level of needing an inpatient hospitalization might be, but we never had or I don't think would seek to have an inpatient level of care for patients. That's what the hospitals are for.

Q I understand. It was a misuse of the term.

Let me just talk about the two jails that are referenced in your CV when you were deputy medical director.

One of those was the Baines Center, that you described?

A That's one of the jails in the New York City system. It had no infirmary, though.

Q But in your CV, you say you directed and delivered health services in two jails.

One of those was the Baines Center; is that correct?

A Yes.

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Q And the other was what?

A There were several times where, for a short period of time, I would be providing care in one specific place.

So we had a circumstance in our infirmary where, for a short period of time, we in correctional health services became directly -- more directly involved in providing care. So during that time I worked in that facility.

I think there are other -- there are other jails where, for a short period of time, I would have been involved more directly than I was normally.

Q So can you identify the second jail that is referenced in your CV, or are you saying there was not two designated jails where you directed and delivered health services?

A What I'm saying is, I think there would have been more than two, but -- and this maybe is a point of clarity that I need to fix in my CV -- I was never only assigned -- like, since I was the deputy medical director, I would spend time in facilities providing and directing care, but nobody was making that -- putting my name, for

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instance, onto the medical director, I don't know, organizational chart.

Q Well, let me approach it this way. What is the smallest correctional facility at which you provided direct patient care?

A I think that the west facility in Rikers Island had about 30 or 40 people. I think that the -- it's a little -- I'm struggling because there are -- I provided direct patient care in every one of the jails, just not consistently.

So I, for instance, would respond to cases where a patient was injured in a use of force. I would provide care. That probably happened in every one of the jails.

And so the smallest, by number, facilities were the west facility and the infirmary, which could have had 30 to 50 patients in the west facility and maybe 100 patients in the infirmary.

Q And how many detainees are held in the west facility?

A I think it's just, as I said, 30 or 50.

Q And what's the role of the west facility in the system?

A People may be there getting screened for

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communicable diseases, or they could be there -- I think it's primarily people who are awaiting or getting screened for communicable diseases.

Q Is the infirmary that you referenced referred to as the northern infirmary command?

A Yes and no. My recollection is there were two pieces to the northern infirmary. Command One is a building. It's a regular, very old jail structure, and I guess I should have included that. That could have 30 to 100, maybe, people who are just incarcerated in old-style cells.

And then next to it is the part of it that's the infirmary, which had, I don't recall as I sit here, but maybe about 100 patients.

Q I read testimony in which you were asked about the smallest facilities at which you rendered patient care. And your answer was the NIC and the BCBC [sic]. Is that accurate?

A I think what I just said kind of comports with that. I don't actually know the numbers of these places, but certainly VC, Vernon C. Baines Center, is a place where I consistently saw patients, and so that's a bigger -- or medium-size jail. And then the NIC infirmary

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is smaller, and I also would have seen patients there.

Q So during this time that you were deputy medical director, were you assigned to a particular jail primarily on those two clinic days?

A No. I set that up on my own. The role didn't require dedicated clinical time.

Q And the NIC infirmary had 100 beds in the infirmary itself; is that correct?

A I think there might have been 100 people. There were all sorts of -- some of them, as I recall, were general population, beds for people with disability accommodation. And then a smaller number were for people with specific health problems.

Q The Baines Center had about 800 detainees; is that accurate? Is that a good guess?

A I don't actually recall. That doesn't sound far off, I just don't recall.

Q And did it have a designated infirmary?

A No.

Q And the NIC, N-I-C, did have a designated infirmary; is that correct?

A Basically, part of the NIC functioned as an

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infirmary for the jails that were on -- for men that were detained on Rikers Island.

Q And is it true that there was 24/7 staffing by physicians available at each of the Rikers Island facilities?

A Not always. For -- some of the jails handled new admissions, and some did not, and so for jails where new admissions were coming in, we generally had 24/7 providers. And when I say "provider," I mean, as a technical term, a physician, a physician assistant, or a nurse practitioner, but there could have been times where jails that didn't do new admissions might not have a provider for a shift overnight.

Q And the urgent care facility on the island was staffed, I assume, by providers 24/7?

A Yes.

Q And did the infirmaries have x-ray capabilities?

A Plain x-ray was available on Rikers Island, not necessarily in the infirmary. There were a couple of ways, depending if it was a male or female patient, to obtain x-rays, but -- and for a while we did have some mobile x-ray units, but not physically inside the infirmary.

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Q Did each of the facilities have EKG machines?

A Yes. That's a basic requirement of a jail treatment room.

Q And was there a pharmacy dedicated to the needs of the correctional facilities at Rikers?

A Yes.

Q And was that available 24/7?

A I'm not sure. It depends what you mean by "pharmacy." People could get medications they needed 24 hours a day, seven days a week. The method by which they got those didn't always involve going to a separate place, a pharmacy. But people certainly had access to the medications they needed every day of the week, 24 hours a day, or we would send them to the hospital if they didn't.

Q Dr. Venters, were you ever terminated or let go from any of your positions?

A No.

MS. MAKAR: Doug, I need a break soon.

MR. KNOTT: Okay. Just let me finish up a couple of topics, and I will -- it'll be within five minutes. Is that all right?

MS. MAKAR: Sure. Thanks.

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MR. KNOTT: Okay.
BY MR. KNOTT:
Q Community Oriented Correctional Health Services, it looks like you were president for three months. Is that accurate?
A I don't actually know how long I was president. There was a time where I worked with COCHS, and that was probably a year and a half, and part of it I had a title, I can't remember, as a fellow, and part of it I was the president. And then when COVID hit, I moved on.
But it wasn't -- it didn't last as long as either of us thought, the organization or myself, because of COVID, really.
Q Does the organization continue to exist?
A Yes, although they're mostly Medicare policy now.
Q At the time that you were affiliated with that organization, was it advocating certain policies related to correctional health care?
A Yes, primarily relating to oversight and use of federal funds for people who are in jails and how records are stored. And, yes, I think that continues to be their kind of main area of focus is the Medicaid waivers for use of

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federal funds in correctional settings.
Q Just kind of extracting from what you just said, my guess is that it was advocating for use of federal funds to implement electronic medical records in correctional facilities. Is that accurate?
A No. Actually, the electronic medical record work they did is old. It's kind of, I don't know, probably 10 or 15 years old. But most of their work in the last decade has been -- and this has now come to fruition -- advocating for states to be able to seek a waiver, because it's prohibited, to seek a waiver so that they can use funds to provide care to people in a jail or a prison, all types of care, especially as they're getting ready to go home.
Q Did the U.S. Department of Justice or federal government take legal action against New York City for management of the health care in jails while you were working there?
A Not as relates to provision of care. There was a civil rights investigation, which we provided quite a bit of data for, on brutality, on physical abuse of our patients.
Q I understand.

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MR. KNOTT: Okay. We can take a break. It's 10:22. You want to come back at 10:30?
MS. MAKAR: Perfect. Thanks.
(A recess was taken from 10:22 a.m. to 10:33 a.m.)
MR. KNOTT: Okay. We can go back on the record.
I just want to put on the record that during the break, I had an opportunity to talk with my paralegal, and the materials we received do not include any of the records that Dr. Venters reviewed.
So I'm going to repeat and ask that you comply with the duces tecum, which was for the complete file and all the materials you reviewed. And in particular --
MS. MAKAR: Doug, are you asking for us to, in addition to the list with all the Bates numbers, to give you the actual production that everyone has? Okay. That's just not our usual practice, to redistribute the production. Because the list has the production. So it was actually me who told my paralegal, you don't need to upload the entire

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production as long as you have the Bates numbers listed. And then everything that wasn't listed by Bates number, she uploaded to the Hightail link that came along with the report.
But if you want -- if you want everything that has a Bates number, you know, physically emailed to you as well, we can do that.
MR. KNOTT: I don't want to -- if that's your practice and that's what you thought you were doing, I don't know why you told me a few minutes ago that you had sent those earlier but --
MS. MAKAR: Well, I didn't understand that you meant you wanted everything that had a Bates number re-sent to you. I meant that we -- we were just talking past each other.
MR. KNOTT: Okay. It's actually broader than that. I want -- I want the files in the format that he received them, and I want any kind of correspondence that discusses these patients or lists them or anything like that. If there's a spreadsheet that lists these inmates and their Bates numbers, I need to

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know.
MS. MAKAR: Yeah.
MR. KNOTT: If there's records that you sent to him, but he doesn't think they're pertinent, weren't referenced in the report, I need to know that.
MS. MAKAR: Right. He just received -- he did not receive anything within the body of the email, didn't receive any discussion, any spreadsheet. He just received blank emails with attachments with the subpoena response. So we can forward those to you. That's fine. It just -- you know, I thought it would be duplicate work, and it's usually not my practice, but I'm happy to do that.
MR. KNOTT: Well, in the context of, you know, him saying that he received it by Dropbox or something like that, it seems like it should be pretty simple to send the materials that were provided to him in the format that they were provided to him.
MS. MAKAR: That's fine. I misinterpreted your rider, and I will do exactly what you just described.
MR. KNOTT: For instance, Maria, he

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describes -- the report describes 4,000 pages of Gallagher Bassett materials and 26 patients, and the 4,000 pages are more than 26 patients. So I just need to know how those were conveyed to him.
So I think we understand each other there.
BY MR. KNOTT:
Q Dr. Venters, I'm trying to get a handle on the nature of your practice in providing direct care in a correctional facility, and maybe I'll just approach it this way.
Are you able to identify the jail or prison you've worked at that most closely approximates, in your opinion, the Monroe County Jail? Is that something you could do?
A No. I haven't undertaken a review of the scope of practice or the clinical presentations of patients. I haven't examined the physical layout. So, no, the short answer is no. I have provided care to a wide range of people and patients, but I haven't undertaken an assessment of the scope of practice or services in the Monroe County Jail so that I could compare that to a specific jail that I've

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provided care.
Q Do you know how many detainees are held at the Monroe County Jail, the capacity for that facility?
A No.
Q Do you know what the health care budget was for the New York City jails when you were the chief medical officer?
A I do not.
Q Would you agree with me that the -- well, strike that.
So I've heard you reference a phrase "jail-attributable deaths." Is that a metric that you've coined for some of your work in assessing health care and mortality in jails and prisons?
A Yes.
Q And my understanding is that you -- the reference to jail-attributable deaths is a reference to deaths in jail that you believe are the result of some preventable systemic or individual decision making?
A I don't know about decision making, but certainly if a person dies behind bars and the mortality review reveals information that

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includes information that indicates that the patient did not receive the standard of care and that something that happened, some occurrence behind bars significantly led to their death or made a significant contribution, then those are cases that we would consider a jail-attributable death.
Q And there were jail-attributable deaths at the New York City jails while you were chief medical officer there, correct?
A Yes.
Q And you've stated publicly that the number of jail-attributable deaths in the New York City jails while you were a medical director got as high as 50 percent of the deaths in the jail. Is that fair?
A I think there might have been a year where it was very high, I think it was usually lower, like 15 or 20 percent, but there was one -- at least one year where we had quite a bit of violence and lots of solitary confinement, where we identified a large number, or a larger percentage.
Q So just so I understand that, taking all deaths of people in custody in the New York City

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jails, it was typically -- did you say 10 to 15 percent of the deaths?

A That's my recollection. I don't -- I haven't kept those data, so -- but most years it was much lower.

When we looked -- it doesn't mean that there weren't areas that we needed to improve, but the actual outcome of death being attributable to something in the jail was usually 15 or 20 percent is my best recollection, maybe lower.

Q And in your use of the phrase, that those deaths were, in your opinion, preventable deaths, correct?

A Yes.

Q And in certain years, the number of jail-attributable deaths while you were acting as medical director got as high as 50 percent; is that true?

MS. MAKAR: Objection. Form.

THE WITNESS: I think it was one year, and I -- and I was either the chief medical officer or the medical director. I don't recall.

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BY MR. KNOTT:

Q And do you feel like you have any personal responsibility for those preventable deaths?

MS. MAKAR: Objection. Form.

THE WITNESS: I felt and continue to feel like it was my responsibility to find those problems and fix them.

BY MR. KNOTT:

Q There's a period of time between your completion of undergrad and your start of medical school.

Let me just ask, did you work in a correctional setting in any regard during those years?

A No.

Q And do you currently have any academic positions?

A I'm not sure what you mean. I have what's essentially an adjunct position at the New York University School of Global Public Health, but that's a -- you know, adjunct means it's not a paid position. I'm not a paid employee. I provide little day-to-day role there.

Q And you don't have an office there, for instance?

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A Correct.

Q And you don't have regular teaching responsibilities there, correct?

A Correct.

Q And is the College of Global Public Health a medical school?

A No.

Q And your CV refers to you as an award-winning epidemiologist. So what awards is that a reference to?

A I think one of them was in 2014. We conducted an analysis of the link between solitary confinement and self-harm. And that paper, which was from records at Rikers Island, was identified by the American Journal of Public Health as the outstanding paper or publication for the year.

Q I represent a company called Advanced Correctional Healthcare.

Have you encountered Advanced Correctional Healthcare prior to this case?

A Not that I recall.

Q Are you familiar with anybody that works for or has worked for Advanced Correctional Healthcare?

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A Not that I know of.

Q Prior to your being named as an expert in the case, there was a physician named Dr. Jeffrey Keller, who testified on behalf of the plaintiffs.

Are you familiar with Dr. Keller?

A I'm not sure, actually, if we've met or if I know him or not.

Q Were you told why you were made a part of the case?

A No. I was told that somebody had been involved in the case before me and was no longer part of the case.

Q Were you told why?

A I don't -- no, I don't think so.

Q And were you provided his deposition transcript or any portions of the transcript?

A No, I don't believe so. I certainly haven't looked at anything that that physician did or said.

Q Were you told what he said in his report or in his deposition?

A No, I don't think so.

Q There's a co-author on some of your papers by the name of Keller. I assume that's not the

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same person.
A No. That would be Alan Keller, who's a physician who works at the Bellevue Program for Survivors of Torture at Bellevue Hospital in New York. So I assume that's not the same person.
Q When you identify deficiencies in your report, what standard are you applying?
MS. MAKAR: Objection. Form.
THE WITNESS: I would apply my own opinion about the standard of care in a jail setting. And when it's relevant or applicable, I would also apply the standards of the National Commission on Correctional Health Care for some of the areas where it's relevant.
BY MR. KNOTT:
Q Is it your opinion that the National Commission on Correctional Health Care establishes the standard of care on the topics it addresses?
A I believe it's one source of standards. Many of the parts of correctional health care that are relevant to, say, a disease, for instance, they wouldn't have any input on those standards. So there it might be the professional organizations or clinical

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standards of care that are more relevant.
Q Have you -- strike that.
There is certification available for correctional health care. You understand that.
A I'm not sure what you mean by that. Do you mean the accreditation that a facility can seek?
Q I think there's certifications for individual health care providers, if we're not communicating on it.
Anyway, you have not sought any particular certification personally specifically with respect to correctional health care; is that true?
A That's true.
Q And there is accreditation of facilities available through the NCCHC, correct?
A Yes.
Q Have you ever -- strike that.
Did any of the facilities for which you were medical director or assistant medical director or deputy medical director have NCCHC accreditation?
A I think we went through the process for one of the facilities when I was at Rikers. Or when I

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was in the New York City jails.
Q Which facility was that?
A I think it was the Manhattan Detention Center, if I recall correctly.
Q And did you succeed in obtaining NCCHC accreditation?
A I believe so, yes.
Q And did you attempt to obtain NCCHC accreditation for any other facilities?
A I don't think so.
Q You have not taught courses for the NCCHC; is that true?
A I've provided talks at their request. I don't know that they -- but that's all I can say, is that they've invited me to give talks, but I'm not sure how that compares to what you asked me about.
Q Okay. You referenced earlier that the -- that you would apply the standard of care. What do you mean by that?
MS. MAKAR: Objection. Calls for a legal conclusion.
THE WITNESS: It means what I view as the appropriate course of action for a specific clinical scenario or clinical case.

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BY MR. KNOTT:
Q And if you assume the standard of care is what a reasonably trained nurse would do under the same or similar circumstances, do you feel you're capable of speaking to the standard of care of a nurse in general?
MS. MAKAR: Objection. Form.
THE WITNESS: Yes.
BY MR. KNOTT:
Q And what is the basis for your expertise in nursing, such that you could speak to the standard of care of a reasonable nurse?
A In my role as a federal monitor, I am charged by multiple federal courts with assessing the adequacy of nursing care.
Also, in my prior role in the New York City jails, I am -- I was in oversight of adequacy of nursing policies and practices and care, obviously in coordination with nurse managers and other staff.
But that has been a core part of my work in the jails and as a core part of the responsibility that is currently asked of me or given to me by federal courts.
Q And to the extent that you supervise nurses at

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any time, you had directors of nursing that reported to you, correct?
A Certainly for quality assurance and policies, yes, and for most day-to-day operations. But in working in a clinic, there might have been more direct interaction.
Q In terms of chain of command, you did not have direct responsibility for supervising frontline mobile nursing, true?
A I think that's largely true, yes.
Q And if you assume that the standard of care is what a reasonable, similarly trained nurse practitioner would do under the same or similar circumstances, do you believe you're qualified to speak to the standard of care of a nurse practitioner?
A Yes.
Q And what provides the basis for you to speak to the standard of care of a nurse practitioner?
A It would be very similar to what I just said regarding nursing. It's been my responsibility directly overseeing care, and also now as given to me by federal courts, to assess the adequacy of care provided by providers, which would include physicians, nurse practitioners, and

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physician assistants.
Q You obviously have not received any formal education in nursing, correct?
A That's correct.
Q You've not gone through the training that a nurse practitioner goes through, correct?
A That's correct.
Q Both have licenses to practice that you do not have, right?
A That is correct.
Q There are professional organizations for both nurse practitioners and nurses. You're not a member of any of those organizations, correct?
A That's correct.
Q You don't -- well, strike that.
You did not consult any treatise or publication specific to nursing with respect to your opinions in the case, true?
A Other than what I've referenced in my report, there's nothing else I referred to as a reference material for this case.
Q If I asked you to identify, like, a leading treatise on basic nursing, you wouldn't be able to do that, right?
A I don't know. As I sit here today, I'm not

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sure what you're asking, but I don't have any, for instance, basics of nursing or what part you're referring to. But, no, I don't have any nursing textbooks or the names or titles of them identified in my head.
Q If I were to ask you whether there's a standard textbook that's followed in instruction of nurse practitioners, you would not be able to identify that, correct?
A No.
Q Have you ever testified in a case that an individual nurse breached a standard of care?
A I believe so, yes.
Q Have you ever testified in a case that an individual nurse practitioner breached a standard of care?
A I believe so, yes.
Q Have you ever been excluded or precluded from giving testimony in a case by ruling of a Court?
A Not that I'm aware of. I don't -- I think there might have been a case where a Court said I should not provide security advice, if I opined on, like, something a security staffer did, but I'm not aware of any instance where a

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Court excluded medical opinions or assessment of health care opinions.
Q There was a challenge to your qualifications to give opinions about security staff?
A I don't actually know that there was a challenge. I think a judge might have said, Dr. Venters can opine on the health response, but not what the security officers did, but I don't actually recall.
Q And do you remember what state it was where that lawsuit was venued?
A No. It was an immigration detention facility. It was -- I don't recall. It must have been five or six years ago, a few years ago.
Q I think I asked you whether there were ever -- whether there was any case in which your testimony was actually excluded or precluded.
To your knowledge, has there ever been a challenge by the other side to your competency to testify to the standard of care of a nurse?
A I don't know.
Q Same question with respect to a nurse practitioner.
A Similarly, I don't know.

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Q You reference in your report some training slides from ACH.

Do you have specific criticisms of the manner in which Nurse Fennigkoh or Nurse Pisney were trained by ACH?

A The criticisms I have are the ones that are in the report, and so as I sit here today, I don't recall critique of the approach to training, but I would -- for any question, I would say if it's in -- the report includes the totality of my opinions as I have -- you know, as of today.

Q I need to know more specifically what your criticisms are. And is it fair to say that you don't know, substantively, what was taught to Nurse Fennigkoh in regard to her performance of duties at the Monroe County Jail?

MS. MAKAR: Objection. Form.

THE WITNESS: I've reviewed training slides. I'm not sure -- and I believe I've referenced in at least one area of the report training slides, but I'm not -- I don't recall reviewing other information about the approach to training.

And so I'm happy to, for instance, do a word search of "training" in my report, if

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you want, but that's -- what's in my report reflects my opinions.

BY MR. KNOTT:

Q I'm trying to -- I understand you have criticisms of the practices. What I'm trying to understand is whether you have the basis for giving an opinion about the substance of the training that was provided --

MS. MAKAR: Objection.

BY MR. KNOTT:

Q -- on that basis?

A And, again, the criticisms I have, which include at least one reference to slides that may be used in training, but other documents, which I don't know if they were used in training, such as policies or forms, those are the substance of my critique. And other -- I don't have other opinions that I haven't shared relating to training or the adequacy of training.

Q And my understanding from review of your report, is that to the extent you reference those slides, you are not critical of the content of those slides; is that fair?

MS. MAKAR: Objection. Form.

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THE WITNESS: I would like to review my report, with your allowance.

BY MR. KNOTT:

Q Sure.

A I really see just two places where I reference training slides, and neither of them appears to be critical of the content.

Q I apologize, Doctor, but I'm getting a signal on my computer that it's going to log me off, so I have to send in a code or something here.

With respect to the NCCHC, Dr. Venters, the NCCHC accredits -- it performs audits and accredits jails and prisons; is that correct?

A Yes.

Q Are you aware of whether a private correctional health care provider company can be subject to NCCHC accreditation?

A I am not.

Q Doctor, do you have a recollection of reviewing the contract between Advanced Correctional and Monroe County? And I'll say that I -- it's not specifically referenced in your materials reviewed list, but I have a recollection of seeing it in a larger group of the materials.

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But tell me if you --

A I don't recall. For this case, I was mostly focused on the clinical documents. So as I sit here today, I just don't recall.

Q Do you know how many nursing hours were contracted for in December of 2019?

A No.

Q Do you know how many medical staff hours were contracted for in 2019?

A No.

Q And I asked you whether you had served as a provider on call for any facility. And you said there were certain circumstances where you were; is that correct?

A Yes.

Q Was there ever a circumstance in where the conduit to the information that you received was the security staff?

A It could be somebody on the security side. Probably not the frontline security staff, but a security -- somebody on -- a senior person on the security side, like a warden or a supervising warden or commissioner might call me.

Q You understand that it's common practice in

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small jails in states like Wisconsin that there is not 24/7 staffing by nursing or physicians?

A Yes.

Q And you understand that there are jails in which the direct contact with the physician, when the nurses are not available, is the security staff? You understand that's a common practice, true?

MS. MAKAR: Objection. Form.

THE WITNESS: That is a practice I've encountered. I couldn't say how common or uncommon it is, but it's certainly something I'm familiar with it.

BY MR. KNOTT:

Q Are you critical of any jail that doesn't staff nursing 24/7?

A No. Many of the places on the monitor are very small, and it's not a -- on its own, it's not something that I would be critical of.

Q You reference certain emails in your report as evidence that financial considerations may enter into the medical decision making at the jail or may have entered into the decision making with respect to Ms. Boyer. Am I correct?

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A I'm not sure you are. I referred to email communications, but I'd be happy to -- if you have a specific area, I'd like to look at it.

Q Well, what I'm getting at is what basis you have, if any, to suggest that financial considerations entered into the care provided to Ms. Boyer.

A Is there -- can you lead me to a point in my report that says what you just said I said?

Q Well, I guess I'm trying to understand whether that is your opinion and whether the -- whether you have a basis for it, if you had that opinion.

So we can look through your report, but before we do so, is it part of your opinion that somebody was cost cutting, and that was a reason why Ms. Boyer allegedly did not receive adequate care?

MS. MAKAR: Objection. Form.

THE WITNESS: All right. So I will -- because you've used some very broad and definitive terms that I didn't use, and so I would like to refer to my report as the source of my opinions, as opposed to you assuming what's in my report.

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BY MR. KNOTT:

Q Okay.

A And I see a sentence on page 24 at the top. I'm not sure if this is what you're referring to, but the sentence says, "Whether from cost concerns, or simply from lack of attention to the standard of care in correctional health, ACH did not ensure that patients who needed provider-level assessment, including during potential medical emergencies, received the standard of care."

So that is an area where I had reviewed the emails, I think that you just referenced, and that is certainly very different than what you just postulated to be my opinion, which is evidence of the financial concerns being the cause or sole cause.

But that sentence in my report, I think, is a good approximate -- that's my opinion.

Q And can you take me there again? What page are you referring to? I think you said page 24.

A Yes. The report I have at the top of page 24, the paragraph starts halfway down, maybe, page 23, but the concluding sentence, which is

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near the top of page 24, says, "Whether from cost concerns, or simply from lack of attention to the standard of care in correctional health."

And then my conclusion there is that patients weren't receiving the standard of care. I didn't say there that it was definitive or I had evidence that it was simply because of financial concerns.

Q So the question I have, Doctor, is whether there's any basis, other than the emails you cite there, for an opinion that cost concerns may have impacted Ms. Boyer's care.

MS. MAKAR: Objection. Form.

THE WITNESS: The information that I've relied upon for the opinions that are in the report are cited there, and so I think that the report speaks for itself. And the emails, I believe, are the only area where cost or financial costs were being specifically mentioned.

BY MR. KNOTT:

Q So with all respect, your report -- I have your report, I've read your report, and I'm entitled to ask questions about the basis for the

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opinions expressed in the report, and saying that your opinions are in the report is not sufficient.

So what I want to know is whether there is any basis, other than the emails you cite in that paragraph, for the statement that cost concerns may have entered into Ms. Boyer's care.

MS. MAKAR: Objection. Form. Leading.

THE WITNESS: I don't see in my report any reference to or reliance on information other than the emails.

BY MR. KNOTT:

Q And I'll represent to you that there were thousands of pages of email communications exchanged in this case.

Were you provided any email exchanges other than those referenced in that paragraph?

A I don't recall.

Q Did you ask to review any additional correspondence between Ms. Fennigkoh and Mr. Hendrickson?

A Not that I recall.

Q You have no information about Advanced

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Correctional Healthcare's financial condition; is that true?

A I don't believe I'm aware of that or have reviewed anything -- any information like that.

Q Well, my understanding is there is no written document, other than those emails, that you're referring to when you postulate the possibility that cost concerns entered into the care that Ms. Boyer was given.

Am I correct in that understanding?

A I believe that is true. I'm just reviewing those paragraphs. I'm not sure I can do that all at this moment, to see whether or not there's any reference to deposition testimony, but it looks like in these paragraphs, the quotations are just from the emails.

Q Do you agree with me that saving the detainees from unnecessary charges is a valid concern for a correctional health care provider?

A Yes, it could be.

Q Do you know -- strike that.

Do you know whether Ms. Pisney was ever made aware of Ms. Fennigkoh's concerns, as expressed in those emails?

A I would need to review these paragraphs to see if there's any reference to -- it's not clear from my review of these paragraphs if or how that communication occurred.

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Q So you don't have any information to suggest that Ms. Pisney was ever advised of Ms. Fennigkoh's concerns, true?

MS. MAKAR: Objection. Form.

THE WITNESS: I don't believe I have any information that shows that that occurred.

BY MR. KNOTT:

Q And referring to the materials you reviewed, on page 4 there's a reference to ACH corporate policies and procedures. Do you see that?

A Yes.

Q And was it your understanding that the document referenced there was a policy authored by Advanced Correctional and that it constitutes the entirety of their policies and procedures?

A I don't -- it was my understanding that these are -- those are ACH policies. I don't know and I didn't form an opinion about if they have some other policies of a different scope, but it was my understanding that those reflect ACH policies.

Q I'm going to put a document on the screen, but

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let's just, for kind of housekeeping, I've been referencing your curriculum vitae, and I want to mark that as an exhibit for the deposition.

MR. KNOTT: Pursuant to the conversation we had before the deposition started, what I'm going to do is provide those to the court reporter, along with the number of the next exhibit, and we'll make sure those are designated.

Is that okay to everybody?

MS. MAKAR: Yes.

MR. KNOTT: Okay. And the reason we can't just -- I think that we have a continuous exhibit plan here, and I'm not sure what the next number is.

BY MR. KNOTT:

Q But at any rate, your CV that was provided to us and which we've been referencing, will be marked as an exhibit.

Doctor, do you have -- well, do you have access to the document that was provided to you and described as ACH corporate policies and procedures?

A It may take me some time to find, because as I recall, it's a very long -- there's, like,

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50 -- there's quite a few PDFs, and they don't have titles. So do you have a Bates number?

Q Hold on. I think I can share it with you.

And I'm putting up on the screen the document. Am I sharing here?

A Yes.

Q Okay. I'm putting up on the screen a document Bates numbered Monroe County 010071 and -72.

And that's the Bates referenced in your list of materials reviewed, correct?

A I'm not disputing that. I'm just not sure. Yeah, I'm not disputing that. I just don't -- I'm not sure where to see that.

Q Oh, the Bates?

A I see that, that that is the Monroe County policy.

Q So in your materials reviewed, these pages are described as ACH corporate policies and procedures.

Did you write that description, or was the file titled that?

A I don't recall. I recall that there was a file that had the -- one PDF had the ACH policies, and one had the Monroe County policies, and I think I'm -- and that they're differently --

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they're also differently titled. Like, the county policy is like this, has like a -- these are basically copy-and-paste to the NCCHC policies at J, and then that the ACH corporate policies had like a -- just two numbers, like 0-1 or 1-2, but I don't recall the titles of the files.

Q Okay. Well, can you tell me where you obtained the information that's put in your report under materials reviewed? Was that your conclusion, or was it somebody else's conclusion?

A Is there a specific citation in the report, like where I cite -- say something about a policy that you're referring to?

Q Well, that's what I'm trying to dig into. So what I'd like to know is whether you have any criticism of an ACH written policy or practice. And this is the only reference I have in terms of materials reviewed. And so let's kind of work through the process here.

I think you recognize that the document on the screen is not an ACH corporate policy or procedure, true?

A Yes.

Q And can you tell me -- and you can take your time to look through your report, I guess -- whether you have any criticism of an ACH corporate policy or procedure, in terms of a written document?

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A Yes. I just pulled up on page 12 -- I recall this also, the chest pain -- there's an ACH chest pain protocol, which has these two -- the 01-01, I think. It's not a Monroe County. It's a -- my recollection is it's an ACH policy. And that it's deficient in the same way that the form in Ms. Boyer's medical records is deficient. And I explained that in the report there, that the kind of lack of guidance on EKG, oxygen, acute coronary syndrome that's present in standard jail chest pain protocols, which I reference both small and large jail examples in my report, is missing both from Ms. Boyer's records and also from the ACH corporate policy that I reviewed, which is, I think, labeled 01-01.

Q Well, again, I think this is the reason why we need to have the files that were sent to you in the native form, because the thing described as ACH corporate policies, you'd agree with me that the exhibit on your screen is not a --

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it's not what is being referenced on page 12, correct?

A Yes, that's true. That's obviously -- and I do elsewhere in the report reference the Monroe County policies. But there, just on that page 12, I see, you know, three different ACH policies, which I think are identifiable by their numbers, 01-01, 13-01, 17-01.

Q And what are you referencing to? Something not up on the screen? Oh, you're referencing page 12 of your report.

A Yes, page 12 of my report, where I say -- I have a whole paragraph -- I have reviewed ACH corporate policies. And then this paragraph lists several policies and then has critique of a couple of them and then also has the number of the policy, as included in the policy document.

Q Okay. So referencing, again, page 4, you agree with me that the alleged corporate policies that you're referencing on page 12 is not the document that is described in your materials reviewed, right?

A Yeah. That looks like a mistake, that that is a reference to the Monroe County policy.

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Q And I don't see any other itemization in the materials you reviewed that would include either Monroe County policies or ACH corporate policies.

Do you see some source of those records?

A Again, that just may -- that may be a mistake on my part, that I didn't list out the correct Bates numbers and maybe conflated -- it's very clear in the report. I say, distinctly, I reviewed county policies and I reviewed ACH policies, but I may have made a -- it sounds like -- it looks like I made a mistake in listing those, the details of listing those.

Q Did you see reference in any of the deposition testimony to illness reports, jail illness reports?

A Maybe, maybe, but I'm not sure what you specifically are asking me.

Q Well, I'm asking you what do you understand the document you reference as chest pain protocol 01-01 to be?

A Well, in my report, I say, "The corporate policies have a chest pain protocol, 01-01." If you're asking for more information about the

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form, I'm happy to consult it, or you could show it to me, but my understanding is if a patient has an acute problem that involves chest pain, ACH has a protocolized form and policy for this specific issue.

Q Is it your understanding that the Policy 01-01 is directions to the physician or nurse practitioner on what to do in an instance of chest pain?

A My understanding is that the nurse practitioners or physicians are usually not present. And so if they do see a patient, they may do a whole separate assessment and plan for the patient, but that this would be a protocol that's used by the nursing staff.

Q Are you familiar with any circumstance in which a jail uses a form for the security staff to gather information in order to make a call to the provider?

A Yes.

Q What do you call those forms?

A Well, it could be the same as this. The form -- when a patient has an acute complaint, a chest pain protocol could involve -- could be used by nursing or security staff in calling --

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gathering information and calling. It's no different than, let's say, a receiving screening that could be done by security staff or nursing staff, but that that happens before the providers are alerted.

Q So your understanding of that type of form is that it is not directions on how the licensed provider will deal with the situation, correct?

A Well, it could be. It certainly -- these chest pain protocols or acute illness protocols can be used by nursing or by security staff.

Q So I think we have a common understanding. These protocols are used by security staff to gather information, or you believe by nursing staff to gather information, so that they can place a call to the physician, right?

MS. MAKAR: Objection. Form.

THE WITNESS: Or they can do very basic things, like call 911 or prevent a -- basic lifesaving care, things like that.

BY MR. KNOTT:

Q And the form does not restrict the provider in their determinations on the next steps in response to the situation, true?

A Yes.

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Q Doctor, can any facility meet the standard of care, in your opinion, if it does not use the designated CIWA or COWS form?

A There should be a standard -- I'm not sure. That's a very broad question. So if you are asking specifically for patients with potential alcohol or opiate or other types of withdrawal, the standard of care is to use either -- these two are the most common tool, but a standardized tool to track symptom severity.

And so that's the standard of care. Without that -- this type of tool, the standard of care is not met.

Q But you could envision a circumstance in which the monitoring is adequate, even though the facility doesn't employ one of those standardized forms.

MS. MAKAR: Objection. Form.

THE WITNESS: Only if the elements from those tools are included. And the most crucial part of these tools is that -- and this is why ASAM, the American Society of Addiction Medicine, and the NCCHC has endorsed these specific tools for a long time.

It's because these tools yield a

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score. And when that score -- and this is absolutely required for facilities that don't have providers on site -- when that score goes up, security staff, nursing staff, they need to know when an elevation in the score is a problem, when it should resolve.

So I've never seen an assessment tool, symptom severity tool, besides these tools, that does that; but in theory, if you took, you know, the ten things from the CIWA, C-I-W-A, or the ten or 11 things from the COWS, C-O-W-S, and you somehow use them differently, but you came up with a score, and then you showed your staff this is the score for mild, moderate, severe, and told them what to do with those numbers, then that could be adequate. I just have never seen that.

BY MR. KNOTT:

Q You were given four depositions to review, right?

A I believe so. I'm not disputing that. I just don't recall, as I sit here, if it was three or four, but I reviewed several depositions, yes.

Q And you didn't make any notes or summarize those in any way, other than in your report?

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A Correct.

Q And given some confusion about what you were provided, I want to ask and make sure I have an understanding.

Were you provided a spreadsheet of any type in reference to your work on this case?

A No. And I don't recall ever seeing a spreadsheet of depositions or cases or anything like that.

THE WITNESS: And just a housekeeping issue. If it's okay, in about a half hour, 45 minutes, I'd like to take a quick lunch break of 15 or so minutes, if that's allowable.

If we're going to -- basically, if we were going to go just another hour or two, then I wouldn't need it; but if we're going to go another three or four hours, then I guess I would like to take a lunch break.

MR. KNOTT: We're going to go a while, Doctor, so --

THE WITNESS: And, sorry, I have a hard stop of five o'clock my time, four o'clock Central.

MR. KNOTT: I understand that.

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BY MR. KNOTT:

Q So I think this is the final topic about what you were given and what you reviewed, but at page 26 of your report, you reference "Review of Additional Cases Among Patients Under the Care of ACH."

A Yes.

Q I just want to make sure that I understand, that other than Ms. Boyer and those 26 additional cases that you reference there, the only records you received are for Kenneth Wilson, Jennifer Lehman, and Larry Schmieder; is that correct?

MS. MAKAR: Objection. Form.

THE WITNESS: I believe that's correct.

BY MR. KNOTT:

Q If there's some other set of records, then I'd like to know it. I'm getting a little concerned about knowing what the scope of --

MS. MAKAR: Okay. I don't know what the confusion is. I'm going to send you everything that's listed there, and we'll make sure that it's all correct. I think he's already answered these questions, but we will

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clear this up.

MR. KNOTT: Sorry about that. Well, the problem is that I'm not sure that I have complete information. So if -- and I'm concerned about the list. So just if we could get some clarification of that, I'd appreciate it.

BY MR. KNOTT:

Q So, Dr. Venters, do you have an opinion on the medical cause of Ms. Boyer's death, other than what is reported in the autopsy report?

A No.

Q You reference in your report that she was treated for an electrolyte imbalance. That's something that you gained from looking at the Gundersen health care records, correct?

A That's my recollection, yes.

Q Do you have any reason to disagree that her cardiac arrest was likely secondary to an electrolyte imbalance?

A I would not offer an opinion. She had multiple potential causes for cardiac stress, and so I would -- electrolyte imbalance could be one of them. There are multiple others. I simply wouldn't provide an opinion about what I think

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caused her heart strain or stress in her terminal period.

Q Do you have an opinion that she entered the jail with some sort of disease process in her lungs?

A I believe she reported, and I'd like to refer to my report --

Q Could you tell us what page?

A Yes. I'm just scrolling up. I'm looking -- I have a summary chart from page 14, where I just put in what was present on the medical screening and then what was in the medical note. And one of the things that was mentioned in the medical screening was asthma. Two other items that are relevant to the lungs involved cancer with chemo and radiotherapy, both of which can cause pulmonary changes and damage, and congestive heart failure, which causes often serious pulmonary congestion.

And so those are -- and then, obviously, alcohol intoxication. If withdrawal ensues, that can have pulmonary consequences, too; but the primary pulmonary issues that would have been relevant, based on what was reported, involved the asthma, the cancer

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treatment, and the congestive heart failure.

Q There was no active cancer treatment, right?

A Not that I'm aware of.

Q She did not have active cancer that you're aware of, correct?

A I don't know. Based on the records I reviewed, I feel confident saying she wasn't actively under treatment.

Q And you don't have any basis for an opinion that she had an acute exacerbation of her asthma condition on her entry to the jail on the 21st, true?

A I don't know. I don't recall her getting a peak flow, so I would say I don't have an opinion one way or the other.

Q I understand your criticism of the intake assessment and timeliness of the intake assessment. My question is whether you have an opinion that an acute condition was present on December 21, when she was being assessed.

A I don't know.

Q Ms. Boyer was intoxicated when she was brought to the jail?

A That's my understanding.

Q Do you have reason to think she was alcohol

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dependent?

A I have no idea.

Q You do not hold an opinion that Ms. Boyer experienced alcoholic withdrawal during the time that she was at the Monroe County Jail, true?

A Not true. We have no idea. She wasn't monitored for withdrawal.

Q So I understand that you have criticisms about the monitoring. My question is whether you have a basis for believing that she actually experienced withdrawal while she was at the jail.

A I think it's possible. I can't conclude definitively, but as I reference in my report, she had elevated blood pressures, which while that could simply be from high blood pressure or other health problems, it certainly is part of withdrawal in its more severe stages.

I also reference in my report that the mental health staff noted several -- they circled several things, I think that she had a labile mood, I can't remember what else, but certainly some of those things would have been consistent with withdrawal.

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They could be consistent with other things, so I can't definitively say, but it's certainly, based on the information I have reviewed, it is not possible to say that she didn't experience some withdrawal. And it could have been from benzodiazepines or alcohol or opiates, three different things, or that those could have been from one or all of those withdrawals.

Q So if I understand your response, you're not able to say to a reasonable degree of medical probability that Ms. Boyer experienced actual alcohol withdrawal during the time she was at the jail.

A Correct.

Q And you're not able to say to a reasonable degree of medical probability that she experienced withdrawal from benzodiazepines during the time she was at the jail.

A Correct.

Q And you're not able to say to a reasonable degree of medical probability that she experienced opiate withdrawal during the time she was at the jail.

A Correct.

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Q Ms. Boyer denied being dependent on alcohol at the time of her intake, correct?
A I believe so. I'm not disputing that. I just don't recall that specifically.
Q One of the questions that was asked was whether she had any concern for withdrawal, and she said no.
MS. MAKAR: Objection. Form.
THE WITNESS: Again, I'm not disputing that. I just don't recall it.
BY MR. KNOTT:
Q I'm going to share with you at this time the Intake Medical Screening Report, which we'll also mark as the third exhibit to the deposition.
Can you see that, Doctor?
A Yes.
Q And is it legible to you?
A As legible as it is to you.
Q Okay. But the size is large enough that you can -- on your screen that you can read the page.
A Yes. I may have to -- yes, that's fine.
Q I'm offering, Doctor, to try to blow it up if you need it, but --

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A I think it's okay.
Q Okay. Question 3 is, "Are you or will you be experiencing alcohol or drug withdrawal?"
And the answer Ms. Boyer provided was "no," correct?
A Yes, I see that.
Q In your experience, are most alcohol or drug dependent arrestees truthful when they respond to that question?
A I don't -- this is asked in a way that strikes me as not very helpful. Most jail intake forms ask a different question, which is, have you ever experienced withdrawal before, and then go through various -- you know, whether it's security or nursing staff ask that.
People who are intoxicated, by definition, aren't experiencing withdrawal. They're intoxicated. So this conflates two very different things.
But I don't think I've ever asked people, are you -- you know, who aren't past the intoxication stage, are you experiencing withdrawal. So I don't know how to answer your question about this issue. But sometimes people report that they are using substances; sometimes they don't.

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Q So the question wasn't -- I understand you have a criticism about the question that was asked. My question to you is whether, in your experience, people who suspect they may have withdrawals are motivated to be truthful in responding to this type of question.
MS. MAKAR: Objection. Form.
THE WITNESS: I think it's variable. That's my experience.
BY MR. KNOTT:
Q And are you aware that Ms. Boyer's husband testified that she's a social drinker and that he had never seen her drunk?
A I don't recall that, but I'm not disputing it.
Q And you agree that it is unlikely that she would experience alcoholic withdrawal if she, in fact, had never been intoxicated?
A I would agree that it's unlikely, if a person used alcohol for the first time, they wouldn't -- they'd be much less likely to experience withdrawal. However, there are people who are social drinkers who experience very serious withdrawal.
Q And by "social drinker," I mean he testified that she had a drink or more two to three nights per week.
Is that type of person likely to experience alcohol withdrawal?
A I don't know. I think that if a person had serious health problems aside from withdrawal, then it could be; but when people drink alcohol, if they also have some other substance in their body or they have -- that precipitates similar withdrawal physiology, or if they have serious health problems, then certainly they could, as a social drinker, drinking a few drinks a few times a week, could experience withdrawal.
Q And Ms. Boyer never expressed concern of withdrawal to anyone at any time she was at the jail, true?
MS. MAKAR: Objection. Form.
THE WITNESS: I don't -- I didn't see any information where she said affirmatively, I'm experiencing withdrawal.
BY MR. KNOTT:
Q And she never told anyone that she was concerned that she may experience withdrawal.
A Correct.

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Q Do you know whether Ms. Boyer was prescribed benzodiazepines in December of 2019?
A I don't know.
Q With the intake screening report back up on the screen, I want to ask you this question, and you can ask me to scroll through.
You agree with me that Ms. Boyer did not report that she was taking benzodiazepines to the people doing the intake assessment on the 21st.
A I didn't see that on the intake assessment form.
Q You agree that if Ms. Boyer did not report to Nurse Fennigkoh that she was -- had taken or was taking benzodiazepines, that Ms. Fennigkoh had no reason to suspect that she would have benzodiazepine withdrawal.
A I agree with that.
Q Do you know whether Ms. Boyer was prescribed opioids in December of 2019?
A I don't. There's a reference to oxycodone use in a nursing note, but I don't recall specifically if she was prescribed anything.
Q Is it important to you whether the drug, the opioid, is prescribed or whether it's being

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obtained off the street?
A Well, in both circumstances, the patient needs to be monitored for withdrawal. The withdrawal could kill the patient, whether it's a prescribed or illicit use.
So from the standpoint of a jail health care service, we just want to start monitoring the patient for withdrawal.
Q And do you have any information about whether opioids were found in Ms. Boyer's system when she was taken to the hospital?
A I don't recall. I don't recall. I recall something besides alcohol being found, but I can't remember if it was benzodiazepines or opiates.
MR. KNOTT: Okay. I think this would be a decent time to take that break that you requested.
MS. MAKAR: And, Doug, my paralegal is, you know, in the process of transferring everything and adding it to that Hightail link that you received in November.
MR. KNOTT: Okay. And I have 12:08. You want to reconvene at 12:30?
THE WITNESS: Yeah, that sounds good

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to me.
MR. KNOTT: All right.
THE WITNESS: Thank you.
(A recess was taken from 12:08 p.m. to 12:33 p.m.)
MR. KNOTT: We're back on the record, and we were just trying to discuss Dr. Venters' access to the files for the individual detainees that are referenced in his report.
And I'd just note for the record, and I understand it's on the way, but, Maria, we have not, as of now, received the email that you referenced your paralegal sending, so I haven't had a chance to access the actual files but --
MS. MAKAR: Yes. You have the Bates numbers for them, but if you aren't able to locate them yourself that way, she's about to send them via ShareFile. She is working as fast as she can.
MR. KNOTT: Okay. Well --
MS. MAKAR: We just usually don't do it that way with items that are Bates stamped, but now that we know that's how you want it, she's going as fast as she can.

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MR. KNOTT: Yeah. So I don't want to repeat myself, but I also don't want there to be an inaccurate record.
So, Maria, this report says that he reviewed -- that he was given 4,228 pages of patient files, and I know that those Bates numbers are from more than 26 patients. So either he found those 26 within that larger group, which I think he denied having done, or he was provided less than that set.
And we've also, I think, identified some other things that were -- that he obtained that aren't listed in the report. Which, I understand, it happens, but I just want to be clear in terms of my ability to know what he reviewed.
MS. MAKAR: I understand. That's why we're going to just make sure we send everything and, you know, do it that way, because it seems there might be a mistake on the list. I understand that.
And she's going to send it. I mean, we're not -- we're not disagreeing. So let's just move on to something where you don't need it, and she's about to send it.

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MR. KNOTT: Okay.
BY MR. KNOTT:
Q Dr. Venters, would you describe yourself as an advocate for change in practices with respect to correctional health care?
A I would say I'm an advocate for patient care, improving patient care. That's certainly my role as a federal monitor, is improving patient care. I'm not sure -- sometimes that involves changing things. Sometimes it involves highlighting things that are, you know, going well.
Q And I'm not being critical or trying to suggest you're not independent. I'm just trying to -- I think you have a unique curriculum vitae, and I'm wondering how you describe yourself in terms of your goals -- your professional goals.
A It's to, honestly, assess and improve the health care and health of people who are incarcerated or detained.
Q And you have, since at least 2017, left the practice of providing direct care, right?
A Yes.
Q And you were with a couple of organizations that were -- that advocated for certain

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policies, right?
A Well, I think I've always -- I mean, when I was with the Health and Hospitals Corporation or the New York City Health Department, they strongly advocated for policies. And when I trained at Albert Einstein, they advocated for health policies. I'm not sure I've ever been part of an organization that doesn't promote, you know, access to health or high-quality health.
Q So you were Director of Programs for Physicians for Human Rights.
A Yes.
Q That's certainly an advocacy group; would you agree with that?
A There is -- a part of their role is advocating for survivors of torture, but probably the biggest part of the work is documenting. So it's doing forensic examination, training doctors and nurses, and training law enforcement to document.
So my work in Iraq, my work with people in Bangladesh who survived the, you know, Myanmar experiences, revolved around training doctors and nurses and law enforcement

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staff, how they can document physical injuries, need for care among people.
Q So the process of monitoring a detainee for drug or alcohol withdrawal involves initially screening for that potential, correct?
A Yes.
Q And then it involves identifying the actual withdrawal, right?
A Well, yes, there's an initial screening for the potential for withdrawal, and then usually at that time, time zero, there's an initial withdrawal assessment done, and then that's repeated every four to eight hours over time to see if the score changes at all.
Q But you would not expect implementation of the severity standard in someone who has not been screened as having the potential for withdrawal, correct?
A If there's no concern about withdrawal, so there's no intoxication, there's no history of withdrawal, nothing raises the concern about withdrawal, then you wouldn't generally initiate monitoring.
Q Is every detainee who comes into the jail intoxicated considered as having the potential

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for withdrawal?
A I think generally, unless there's -- yes, generally. So the guidelines from the Department of Justice, from ASAM generally teach us that when a person comes in, and they're very intoxicated, certainly if they're so intoxicated, they're impaired, we should monitor them as if they might potentially enter into withdrawal, especially for alcohol. That's, I think, especially dangerous.
And then we can stop it when -- you know, the next day or later on, when we're not worried anymore. So generally, when a person comes in and they're intoxicated, especially with alcohol, we start monitoring, and then we can stop it the next day or, you know, a couple days later, if we're not worried.
Q But the actual COWS or CIWA device is not a screening tool, correct?
A It actually, I think in a technical manner, you are -- you know, it's kind of semantics, because sometimes it is referred to as a screening tool, because the actual diagnosis of withdrawal, diagnosis of anything, is done by a provider.

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So an NP, a PA, or a physician has to give a diagnosis. That can't be done by nursing or security staff. But most jail protocols have people identified -- and initially, they've received this tool, this screening tool, the monitoring tool, it's kind of an overlap, but that has to happen right away so you get a baseline score.

And it's a tool that's used -- you know, lots of small jails have correctional officers use this tool, not nurses. But I'm not -- I think it's a little bit semantic as to whether or not it's technically a screening or monitoring tool. The diagnosis comes from a provider, though.

Q So the mere fact that someone uses alcohol or reports using alcohol does not mandate that the COWS/CIWA monitoring tool be implemented, true?

MS. MAKAR: Objection. Form.

THE WITNESS: I guess it depends on how they answer questions like have they ever experienced withdrawal in the past, are there any concerns about withdrawal that are raised, but there are -- if a person is not intoxicated and they haven't had a drink in a long time and

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there's no concern that they're impaired, then those are circumstances where you credibly could say the patient doesn't really need to have monitoring started.

BY MR. KNOTT:

Q I'm concerned about the word -- the use of the word "impaired" there.

So there are detainees who come into the facility who are intoxicated at the time who can be screened out, in terms of potential for withdrawal; is that true?

A No. I think --

MS. MAKAR: Sorry. Objection. Form. Incomplete hypothetical.

THE WITNESS: I think people who come into a facility and are intoxicated and are thought to be intoxicated from alcohol, need initiation of monitoring, and then that initiation can be stopped.

You know, there are all sorts of guidelines for how to stop this and, you know, when to stop it, but certainly you need to start monitoring, because you have no idea, when a person is intoxicated with alcohol, what their real risks are for withdrawal.

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BY MR. KNOTT:

Q So regardless of how that person may answer the screening questions, the monitoring tool needs to be implemented, the CIWA/COWS monitoring tool.

A Well, for alcohol, it would be CIWA. And, yes, it should start and then can be discontinued once you have enough information to say you're not worried about withdrawal. Because the opposite way leads to preventable deaths.

Q Can you tell me what facts you've assumed with respect to the role of Nurse Fennigkoh?

A I'm not sure what the meaning of your question is. The nurse and nurse practitioner I've understood to be employees who worked in this facility. I'm not sure what specific other questions you have about the role.

Q Well, I'm asking about what you understand to be Nurse Fennigkoh's role with respect to her interactions with Ms. Boyer.

A Well, I will -- if it's okay -- I'm not -- I'm still not exactly clear, so I'm going to look in my report to see where I've referenced her, if that's acceptable.

So I first refer to her in my report

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on page 5, referring to a progress note that Nurse Fennigkoh put -- that's present from the medical records for Ms. Boyer. And so my understanding from that is that -- and my assumption is she's a nurse that's employed in the jail to provide care, and then -- and there's discussion in my report about the information she received and documented.

And then I reference another report, also by Nurse Fennigkoh, on page 6, which was a little bit later, on the 22nd of December, at four o'clock in the afternoon.

And so both of those references in my report assume that her role was as a nurse who was working in some form of patient care in the jail.

Q And if I ask you to discuss with me what you understand to be her interaction with Ms. Boyer on the 21st, are you able to do so?

A I'm looking at that reference there on page 5, leading into page 6, and it doesn't appear that she had a physical assessment or encounter with the patient, that this is information that was reported to her as she was leaving the facility, when a Tomah police officer related

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information to her.

Q So tell me what you mean by that. Are you saying that the note that she entered that day was related to her by the Tomah police officer?

A My report says a progress note by Registered Nurse Fennigkoh is present with a timestamp of 2240 on December 21st, and the note reads. And then there's a quote that, from the note, says, "Leaving facility when Tomah PD officer stated, 'I hope you're ready for a medical mess.'"

And so this part of my report includes both that information, and then also, later on, that the nurse found some loose pills in the patient's purse. And it says -- it concludes with, "RN fully explained the difficulty, as her pharmacy is not open Sundays." And so that explanation back to the patient.

Q What you were just doing there was reading and characterizing what you wrote in your report, correct?

A Yes.

Q And just tell me, you're not able to have a discussion with me based on a recollection of the role of Ms. Fennigkoh, right?

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A Correct. My recollection -- I'm able to represent and discuss what's in the report, but I don't have an independent recollection, for instance, of her assignment that day or what she was -- you know, what her overall assignment or role was.

Q And when we get to Nurse Pisney, would that be the same response, that you're able to recite what appears in your report with respect to her involvement, but you're not in a position to discuss, based on your own recollection of the records, what her role was?

A Well, I haven't -- I can't recite my report, to the extent I haven't memorized it, but it is true that my understanding of and impression of the interaction or role of these two staff in Ms. Boyer's care is in my report. I don't have a separate additional understanding.

Q I've put up on the screen the narrative progress note completed by Nurse Fennigkoh on the 21st and 22nd.

This is what you referenced in your report, correct?

A Yes, I see that.

Q And in the second line of the first note,

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Ms. Fennigkoh questioned Sergeant Warren if she felt the patient needed medical clearance, and Sergeant Warren indicated no, the patient has a long history of past medical concerns and is intoxicated.

Do you agree with me that that statement demonstrates that the possibility of obtaining medical clearance at a hospital was available?

A Yes.

Q It means that there was not -- there was not a policy against obtaining medical clearance. You agree with that?

A I don't know. I don't think it speaks to policy. I think that it references the potential for medical clearance to occur in some circumstance.

Q And Nurse Fennigkoh, along with Sergeant Warren, were engaged in a process of interviewing Ms. Boyer to determine whether she was appropriate for admission to the jail. Do you agree with that?

MS. MAKAR: Objection. Form.

THE WITNESS: I would agree that they were interviewing her. It's not really clear

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what the scope of the interview was. But I agree that they had both spoken with her or were speaking with her.

BY MR. KNOTT:

Q And Nurse Fennigkoh at least considered, during her interaction with Ms. Boyer, the possibility of sending her for medical clearance, true?

A I'm not sure that's true. I mean, what's in this note is that a law enforcement officer, who is not a health care professional at all, said this patient doesn't need medical clearance.

And then I don't see a review of whether or not medical clearance was really needed later on in the note. Normally, it would look much different than this, where a nurse does an objective collection of signs, symptoms. And then there's some sort of review near the end about is medical clearance needed or not, and what are the criteria?

Q You disagree with the decision and you disagree with the process, but you agree that Ms. Fennigkoh was exercising her judgment in determining whether she should obtain clearance versus admission to the jail. Do you agree

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with that?
A No.
MS. MAKAR: Objection. Form.
BY MR. KNOTT:
Q Did you answer?
A I disagree.
Q And tell me why you disagree.
A Well, what you've postulated is that she reasoned on her own or evaluated somehow if this patient needs medical clearance.
What's actually in this note is very different. It's that a law enforcement officer said no clearance is needed.
And then there's a review of lots of things that really don't have much to do with medical clearance, some with medications. There's nowhere in here where -- what you just referenced, which was the independent decision-making assessment, you know, whether or not the patient needs medical clearance from the nurse's standpoint. I don't see that documented here. I simply see the nurse starting the note with a police officer says this patient doesn't need medical clearance.
Q Do you know what the plan was at the conclusion

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of this interaction?
MS. MAKAR: Objection. Form.
THE WITNESS: I'm just reading the last part of this note.
I'm sorry. My experience as a doctor is that the nurse would put what they are going to do at the end of your note. So if you want me to respond to your question, I would like to look at the note. Is that okay?
BY MR. KNOTT:
Q Sure.
A Okay. It looks like RN instructed jail staff to alert NP of situation when able.
Q Was a decision made to admit Ms. Boyer to the jail?
A She entered the jail. I'm not sure about the decision, but I assume it was made, since she continued into the jail.
Q And do you have any understanding as to how she -- or where she was housed?
A I don't recall.
Q Is it your opinion that there was some urgent medical emergency that Ms. Boyer was experiencing on the night of the 21st that required immediate attention?

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A I don't know. I think she required assessment by a provider, an in-person assessment, and it's unclear from the -- you know, as I mentioned before, some of the important fact information just wasn't gathered on the way in.
So I wouldn't definitively say I know she was having this type of medical emergency or that type, but as I say in my report, she needed, as an absolute requirement, to be assessed by a provider, given all of the serious health problems she reported.
Q But you're not able to state to a reasonable degree of medical probability that she was experiencing a medical emergency at the time of her admission on December 21, true?
A That's true.
Q Was it reasonable to develop a plan to have the husband bring in her medications and diagnosis list?
A That is not an acceptable plan as the only plan. Certainly getting a medication list from family is important, but it's another reason why the patient needed a provider level of assessment, because it's not a nurse's job to figure out which health problems or which

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medications could be life sustaining or missing the medications could be life threatening.
Q Hold on for a second here.
At page 5 of your report, you reference medications referred to in the medication verification form, and you list them. Are you with me?
A I am scrolling. Yes, I see that.
Q And one of the things you list there is diazepam, which is a benzodiazepine, correct?
A Yes.
Q And what's your understanding as to the source of information about diazepam?
A I can't recall. As I recall, a pill of benzodiazepine was found in her purse, and then I can't recall if also a review of some -- a called pharmacy yielded some information. I don't actually know, as I sit here today, other than that I recall that they found some sort of benzodiazepine in her purse.
Q Anything else you recall about the benzodiazepine found in her purse?
A No, not as I sit here.
Q I'm going to share on the screen the medication verification form that I think you're

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referencing in page 5.
You agree that it looks -- it looks like that's what you were referencing?
A Yes, I think so.
Q And you agree that, actually, diazepam was not identified on the medication verification form.
A I see that.
Q What is peak flow, Doctor?
A It's a standard measurement patients use -- and health care staff -- that patients use to monitor how their asthma is doing. You just breathe into a little plastic device, and it gives you the strength of your, like, breath, exhalation, moves a small plastic piece up, and it gives you a number.
Q Is it standard, used in every intake assessment of a detainee?
A For somebody with asthma, yes, absolutely.
Q And did Ms. Boyer report on the 21st any concern about her breathing?
A No, but I have asthma noted on the form. That's what would have triggered it, not shortness of breath.
Q Can you tell me when Nurse Pisney was initially contacted about this patient? And tell me if

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it's just not something that you're familiar with at this time.
A I have not memorized that level of detail, but I'm happy to consult my report to see. I have her involvement detailed in the report.
Q Is it important for you, in the formation of your opinions, to know when Ms. Boyer initially reported chest pain?
A I think it's important in terms of whether or not staff responded. So it's part of the information I've reviewed.
Q So the question was whether it's important for you to know when she first reported chest pain.
A Yes. And so I would say it's certainly important for me to know when staff were informed. She might have reported it to lots of people, but when the health staff became aware and the security staff became aware, that's kind of where my focus starts.
Q Okay. So when did Nurse Pisney become aware of her reported chest pain?
A I have in my report -- I just looked up Nurse Practitioner Pisney -- on the 22nd, late on the 22nd, as the first time.
Q What page are you referring to?

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A Page 7. And it's where the jail illness report is mentioned.
Q And is it your understanding that her chest pain persisted?
A I'm just reading my report.
Q Let me take you through it.
On page 7 -- and you can read it, if you'd like -- but page 7, you say that the jail illness report at 8:09 references chest pain, correct?
A Yes.
Q And in the paragraph under the bulleted points on page 7, the last sentence is, "No mention of chest pain," in the -- in the note recorded at 8:52, correct?
A Yes, I see that.
Q Is it your understanding that she reported chest pain at any time after 8:52?
A I don't have a -- there's no documentation of that.
Q And you have no basis to believe that she was continuing to experience chest pain after 8:52, true?
MS. MAKAR: Objection. Form.
THE WITNESS: I would say I don't --

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I don't know how long it persisted after -- I assume it didn't stop the second that first note was entered, and so I don't know whether it recurred or whether it continued after that.
BY MR. KNOTT:
Q Bear with me.
Do you know if the NCCHC standard on intake assessment references vitals?
A I don't recall as I sit here today.
Q Do you know if it references peak flow?
A Well, it wouldn't, because it doesn't -- I don't think it contemplates that every person has asthma, but -- so, yeah, I would say no, it's for -- not that I recall.
Q Do you know if it references getting a pregnancy test?
A I think that pregnancy status is referenced in the jail standards, I don't recall where, but everybody coming into a jail should have -- all women should have their pregnancy status checked.
I've actually never encountered a jail that doesn't do that for everybody. That's really a shocking finding.
Q Do you agree with me that it's moot in this

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case, because Ms. Boyer was not pregnant?
MS. MAKAR: Objection. Form.
THE WITNESS: I don't have an opinion about -- and I don't have any evidence to think that the failure to check her pregnancy status had anything to do with her death. I think that's fair.
BY MR. KNOTT:
Q Okay. I want to talk to you for a minute about Mr. Schmieder, who you reference on page 17 of your report.
Do you have access to those records?
A Just a moment. I can -- I'm first going to page 17 of my report.
Okay. I see the reference to him in the report, and I will look for the medical records.
Oh, I see. You know, I'm having trouble looking at the medical records while this camera is on because of the limit to the number of USB ports, because I keep the medical records on a secure drive.
So I can -- so I guess the short answer is no, but I can -- if you show me something, I'm happy to look at it; but

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otherwise, I have to either unplug my mouse, which would kind of make it hard, or unplug the camera, which, obviously, I don't want to do.
Q Well, it's hard, because I don't want it to be a memory test, but --
A You have his medical records. You have access to them. Can you show them to me, like you did the other thing?
Q I have immediate access to a few pages, but let me try to lead you through those.
MS. MAKAR: Jessie should have just sent you everything. So it should be in your in-box in a second, if it's not already.
BY MR. KNOTT:
Q So I've shared on the screen Mr. Schmieder's intake medical screening report from June 30, 2016.
A I see that, yeah.
Q It's Monroe County Bates No. 002850 through -52.
A Yes, I see that.
Q And I can scroll through it, if you'd like, but you're critical of the facility and nursing staff or the health care staff with respect to this intake assessment.

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I have a difficult time talking to you about this without having a common understanding, but is it your opinion that he had some acute condition?
A It's a little unclear. He has serious lung disease, and I have written in my report that he came in with lung disease requiring supplemental oxygen, so pretty serious. And it says there, actually, COPD, emphysema. That's the, you know, red flag. And then down below, in the medications, it just says a lot.
So this is really -- potentially, a very complicated patient that, you know, if he really needs oxygen, the level of his, like, lung function should be figured out by a provider to determine that he's, you know, going to go to the right place or he's going to get the right care.
Q And my question is whether you, reviewing this document, have a basis for believing that he had some acute, rather than chronic, condition.
A Well, he certainly -- just what you have right there. His pulse is elevated, and his breathing is fast, and his oxygen is, you know, low, normal low.

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So just those things right there should trigger an assessment by a provider. It's not a nurse's or a security officer's job to say a fast heart rate or a fast breathing rate or that oxygen of 95 percent is okay. It's not clear.
So I would say there's indication that he had abnormal signs and symptoms and that he had very serious lung disease, and based on that, he needed to be seen by a provider.
Q The reference range with respect to pulse oximetry, O2 saturation, is what, Doctor?
A Well, it's very person-specific. So I would say 94, 95 is probably the lower limit of normal, but for patients with emphysema, COPD, it's important to know what's their baseline. So when a provider did an adequate assessment of a patient, that's one thing they'd probably ask, is, you know, what's your peak flow normally, what's your O2 sat. normally, and how are you on room air versus supplemental oxygen?
Q So what's the reference range for pulse?
A It is usually 60 to 100. I think that, you know, when we think about -- again, for

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instance, when we look at withdrawal, patients in withdrawal, we sometimes think about an 80 to 100, giving us a point if we're doing withdrawal monitoring. And the respiratory rate, again, is mildly elevated. So all of these are mildly off.

Q What's the reference -- I apologize if I interrupted.

What's the reference range for the respiratory rate?

A Usually 16 to 20.

Q So this gentleman with COPD and emphysema has a respiratory rate of 22 versus a normal of 20; he has an O2 at 95, and you describe 94 or 95 as normal; and he has pulse of 101, with a reference range of pulse of 80 to 100 being normal. Am I understanding that correctly?

A Yes.

Q And, again, I understand that you have an opinion that Mr. Schmieder was a complicated patient with chronic conditions.

Do you have a basis for believing that he had an acute condition requiring emergent medical attention on June 30, 2016?

A I don't have an opinion that he was having a

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medical emergency.

Q And do you have enough recollection of this patient to tell me what you mean when you say he deteriorated over the final week of his life?

A I'm reviewing my report, which says his records show multiple phone contacts between custodial staff and an off-site provider, that he deteriorated over the final week of his life, and that he was refusing medications, so -- but I'm happy to look at any of those records. But I don't have an independent recollection of the records.

Q Are you familiar with any standards in the state of Wisconsin for inmate health in jails?

A No.

Q Was it something you looked at?

A I don't -- no, I don't think so. I did review a report by a state agency or investigator, but I don't think I've reviewed any jail standards.

Q And the state report did not identify any flaws in policies at the jail, true?

A My recollection is it had to do with medication documentation. I don't -- as I sit here today, I don't recall how it was phrased or framed.

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Q You wrote about Mr. Schmieder that he was refusing his medications due to concerns over being charged for them.

A I believe --

Q How do I find the source of that?

A I don't recall, as I sit here now, if it was in the notes from a refusal form or in his clinical encounter notes.

Q And this -- no one other than you looked at Schmieder's records in order to reach that conclusion; is that correct?

A I haven't relied on anybody else's opinions or information, so this is my own assessment.

And if you want to take a quick break, I can, like, log out, plug in my hard drive, look at this, or I can review this at a later time. Whatever works best.

Q I would like to know the source of some of this factual information you put in your report, so if that's what it takes, I think we should do that. So why don't we take five minutes.

A Okay. And I'll be back in five minutes.

MR. KNOTT: Thank you.

(A recess was taken from 1:25 p.m. to 1:35 p.m.)

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BY MR. KNOTT:

Q So, Dr. Venters, while we were off the record, you were able to replug in, and as I understand it, you were able to obtain access to the patient files, but you don't have time to get through them to respond to questions that are asked, right?

A Yeah. I was able to get into my hard drive. There's, you know, numerous, numerous PDFs in there, and so I wasn't, in the few minutes we were off, I wasn't able to answer your question.

So as I sit here today, I can't tell you the specific note or citation for the -- what's in that sentence, that he had concerns about being charged for medications.

Q Let me -- I need to be able to talk to you about the factual basis for your opinions, and you didn't flag these records in any way with reference to the facts that you're putting in your report about them, correct?

A Correct.

Q So if I asked you the source of the information that he deteriorated over the final week of his life, can you tell me that?

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A Not as I sit here today. Again, I'm happy to review the medical records, if you want to show them to me, or -- yeah, I'm certainly happy to do that, just as we just did with his intake.

Q And with respect to -- well, as I suspect you know, because Mr. Schmieder's records are available to you, there's 192 pages. So we're not really able to look through that, and I can't find a source for the facts that you're putting in your report.

So if I ask you the source of the information that he deteriorated over the final week of his life, you're not in a position to converse about that at this time, correct?

A I certainly have not memorized those 200 or so pages, but I would be happy to, if there's a specific question, find a page citation and send it across later on.

Q I think I'd ask you to do that, with respect to deteriorated over the final week of his life and medications -- that he refused medications due to concerns over being charged for them. Let me -- maybe we could eliminate the latter.

Do you believe that Mr. Schmieder did not have access to medications because he would

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be able -- because he would be asked to pay for them?

A I actually don't know.

Q Do you know what the policy at the jail is in that respect?

A I understand there's a policy that if people can't pay for their medications, then they would be provided to them.

Q And that is fairly widespread across the country, is it not?

A I'm not sure I would say widespread. Jails -- it's different in prisons, but jails, more often than not, in my experience, do not charge people for their medications, because even though there may be a policy to let people get their medicines if they can't pay for it, those extra steps lead some people to just simply not get the medicine or stop taking it.

So it's my personal experience that it's much more common that people not pay for medicines in jail than it is that they do pay.

Q And you can't speculate about Mr. Schmieder's motivation for refusing his medications that were offered to him.

A I don't know anything other than what I've

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reported from his records, so I have no independent knowledge of his motivations or fears.

Q And I think I asked you whether he was experiencing an emergency at the time of intake. Do you believe he had an urgent medical need at the time of intake?

A Absolutely. He was a patient who, it had been written, was on a lot of medicine, with no effort to say what all those medicines are. He had -- his vitals, as we discussed, were borderline abnormal, so a patient who could be tipping into an emergency.

But COPD and emphysema are leading causes of death. And particularly when patients all of a sudden stop their medications or there's confusion about their medications, an urgent situation with a patient like this can quickly become an emergency. So, yes, it was urgent, absolutely urgent, that he be seen by a provider based on his clinical presentation.

Q And of course you can't talk about when his medications were verified and started in relation to his intake, correct?

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MS. MAKAR: Objection. Form.

THE WITNESS: I'm happy to review the medical records, if you want me to.

BY MR. KNOTT:

Q There's no evidence that Mr. Schmieder felt his care was inadequate, true?

MS. MAKAR: Objection. Form.

THE WITNESS: I don't have an opinion one way or the other. I don't recall seeing a grievance, for example, that he submitted.

BY MR. KNOTT:

Q I'm going to share with you a document Bates labeled Monroe County 002853 from Mr. Schmieder's record and point out to you that this is a list of 14-day health and physicals. And the only inmate not blocked out on that page is Mr. Schmieder, and this document indicates that he refused his physical.

Does that impact your opinions in any way?

A No.

Q Is it your opinion that his death could have been prevented, or do you not have adequate information to render that opinion?

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A I do not have adequate information to give an opinion on that.

Q I assume that if you believed his death was preventable, you would have -- on your review of these records, you would have entered that into your report. Is that fair?

A Certainly if I had reviewed adequate information to make and come to that conclusion, I would have put it in.

Q Doctor, page 24 of your report, if you can turn there.

A Yes, I'm on page 24.

Q And you wrote there that -- under -- in the middle paragraph, the fourth line says, "I have also asked for mortality reviews in other cases of death among patients at Monroe County Jail in the past decade and have not received any such reports."

Can you tell me, did you -- who did you ask?

A Counsel at the beginning of the case, I asked, are there mortality -- clinical mortality reviews that I can review and was told there weren't any that I could review.

Q And were there any deaths at the jail that you

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could identify in the past decade that you expected there to be mortality reviews?

A Well, certainly the clinical mortality review in this case, and then I don't recall if there were other cases preceding or how many there were.

Q Can you identify any cases of medical-related deaths at the jail in the decade prior to Ms. Boyer's?

A As I sit here today, I don't know what -- how many people died beforehand. I think I reference a couple of cases here in my report, but I don't actually, as I sit here now, know the names or the exact dates of when those people died.

Q Can you tell us what would have been learned in a prior mortality review of a death at the jail that would have impacted Ms. Boyer's care?

A There are -- I mean, it's hard for me to summarize in one response. I think that the prior deaths -- a mortality review looks at the patient's care, looks at the standard of care, whether or not it's met, and it finds areas that need to be addressed. And these are often systemic problems.

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And so to the extent that prior cases involved any of the kind of core deficiencies in her case, so failure to do an adequate intake assessment or get medical clearance, failure to institute monitoring for withdrawal, failure to respond to a medical emergency, if those three things were present in prior cases, then what should have happened is that the clinical mortality review would pick that up, use it as a fulcrum for improving workflows and standards of care.

So that's the way this -- that's why there's a requirement in almost every -- I just haven't seen too many correctional centers that don't do these clinical mortality reviews, but my lens would be the deficiencies I see in her case, were those present in the prior cases where people died?

Q And are you aware that under Wisconsin law, deaths in jails are reported to the Department of Corrections?

A I'm not disputing that. I'm not sure I was aware of that.

Q And you're not aware of any -- you're not able to converse with us today about any death at

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the Monroe County Jail that you feel is factually similar to Ms. Boyer's circumstance.

MS. MAKAR: Objection. Form.

THE WITNESS: That's not at all what I said. I'm happy to look at my report, because I've referenced several prior deaths, I think, in the Monroe County Jail. I just want to -- and why the failure to provide -- to do these mortality reviews is really relevant.

I'm just looking through -- so in order to answer your question, I need to look at the cases that I've referenced of prior deaths.

Yeah, so there are two cases where people died from suicide, Mr. Kenneth Wilson and Ms. Jennifer Lehman. They're both on page 34 of my report. And one of the really important features of their cases that is also part of my assessment in Ms. Boyer's case is the lack of adequate withdrawal monitoring. And that is something that should have been picked up in a very basic mortality review, and if it had been addressed, would have resulted in increased medical monitoring for Ms. Boyer.

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BY MR. KNOTT:
Q We'll get to them.
In this discussion of mortality reviews, you reference on page 25, Mr. Xiong, X-I-O-N-G.
Are you capable of discussing Mr. Xiong's circumstance with me?
A I have his part of the report in front of me.
Q You agree with me that the standard that you're referencing with respect to mortality review is procedure in the event of an inmate death?
A Well, these are morbidity and mortality reviews, so M&M, which is the standard term, involves review of deaths and other serious outcomes.
So, for instance -- so there are many circumstances when somebody doesn't die, but there's a serious problem. That kind of medical term for this, M&M, is morbidity and mortality for that reason.
Q So the NCCHC standard on mortality reviews does not reference reviews in the event of morbidity short of mortality, true?
A I would need to look -- they certainly affirmatively say every death needs to be

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investigated. I would need to review as to where and how they reference morbidity, like sentinel events in critical cases.
Q So if the standard JA10 is procedure in the event of inmate death, then you would agree that does not speak to some event short of death, true?
A True. It may be that critical incidents and other events that are short of death, that don't involve death, are referenced elsewhere.
Q So is there some other source that you can cite me to that says there's a standard that requires review of the nature you're talking about, of events short of mortality?
A Well, I think that, first of all, my own clinical practice and understanding of the standard of care in jails is that when we have a near miss, when there's a serious health outcome, which would include any kind of delay in emergency care, that that should trigger a clinical review, and that could be under quality assurance or quality improvement. It also could be under M&M.
Q You know from this discussion, Mr. Xiong didn't die.

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A Yes.
Q Did you know that when you wrote the report?
A I believe so, yes.
Q And Mr. Xiong did not have any chronic medical conditions at intake, true?
A I don't recall his records off the top of my head, but I'm certainly happy to review.
Q His case did not involve any concern for withdrawal.
A Again, I don't recall his medical records as I sit here today, but I'm not disputing that.
Q And if you could do that review and let us know any evidence that he suffered a significant medical event or mortality, I'd appreciate you doing so.
A Well, just hold on there for a second. My position in the report is that when a patient has chest pain, and there's a delay in response, there's no EKG done, that's a significant medical event. I'm not looking at the patient -- the reason these cases are so important for improving our care, it's not that the -- the patient may not die. They may in fact have, you know, a relatively benign problem. But in his case, and the reason it's

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referenced here, is this is an example of learning that should have occurred that doesn't appear to have triggered a different approach. But the medical event was not did he die or not, it was that he had a delay in assessment when he reported chest pain and had normal vital signs on December 20th, 2016.
Q Ms. Lehman and Mr. Wilson did not report chest pain, true?
A Not that I recall as I sit here today. I'm just going up to the section of the report that discusses them.
Yes, I referenced both of those cases because of a lack of withdrawal assessment and monitoring.
Q And do you have any evidence from the records that Mr. Wilson actually experienced withdrawal?
A No. As I just said, it was never -- it didn't look like it was ever assessed. So it would be -- I don't have an opinion that either of them had it. My concern is that they needed it and didn't get it.
Q You had that concern, but you don't have any evidence that actual withdrawal was missed,

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right?
A That's right. If health staff don't do their job, it's impossible to know what happened in that void or that black box. So I don't have any evidence that they were in withdrawal, that's true.
Q And so you -- and you have no evidence that their -- that any abuse disorder contributed to their suicide attempt or suicide.
MS. MAKAR: Objection. Form.
THE WITNESS: Yes. Again, I didn't see -- this would have been an important feature of a mortality review, is to dig into the contribution of either substance use disorder or withdrawal, but the withdrawal wasn't assessed during their incarceration, and then there wasn't a mortality review for me to look at to see if this had been contemplated.
BY MR. KNOTT:
Q But you're a forensic correctional health expert, right?
A I don't know what you mean by the term "forensic," but I'm a correctional health expert.
Q And you have conducted mortality/morbidity

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reviews, right?
A Yes.
Q And you looked at the records for Mr. Wilson, right?
A Yes.
Q And you have no basis in those records for saying that withdrawal contributed to his suicide attempt.
A There's no information for me to say either way. So I know we're going in circles, but if health staff don't measure something, then later on, it's true, we don't know if the thing happened or not. And so the gross deficiency in this care is these patients never got monitored for potential withdrawal.
Q And the fact that Mr. Wilson's event occurred in 2020 means that nothing would have been learned from that that would have impacted Ms. Boyer's care. Do you agree?
A Yes.
Q And Ms. Lehman, L-E-H-M-A-N, you have no basis to offer an opinion that she experienced actual withdrawal, correct?
A I would say, again, I have no information either way.

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Q And you have no basis to offer an opinion that a failure to address her withdrawal contributed to her suicide.
A I have no information either way.
Q Would it be important to you, as a scientist, to know that you've reviewed the entire available medical record before you offer opinions?
A Well, I think it's important to reflect the opinions -- that the opinions I give are based on a clear set of information. It's often the case that, for instance, family members have important information or other sources of clinical background would -- might inform my opinion. So the most important thing, from my standpoint, is to say, you know, which -- the scope of types of records that I reviewed.
Q Doctor, do you have any basis to suggest that ACH uses a business model that underbids rivals by cutting back on referrals of sick detainees to outside care providers?
A I don't have an opinion about that.
Q Do you have an opinion that ACH trains all of its new employees to discount the medical concerns of jail detainees?

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A I also do not have an opinion about that.
Q Do you have any evidence to suggest that ACH pressures its practitioners to reduce or delay care?
A The only evidence or indication I have about financial concerns is included in the report, and I think we've already talked about that, where I reference emails and say it could raise a concern or it could raise a potential concern, but I don't make the conclusion definitively about what I know is happening.
Q I'm about to wrap up and let these other folks ask their questions.
Doctor, have you ever been accused of professional malpractice?
A No. I was a defendant in a jail case where I was named, but it wasn't a patient I saw or provided care to. It was in my role as the -- I think the medical director or the chief medical officer.
Q To your knowledge, how many times have you been named as a defendant in a case?
A I think one or two.
Q Do you know whether any of those cases were settled?

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A I don't know. I assume they must have been settled, because I think I listed the deposition of one of them at the end of my CV, and after the deposition, I never heard from the law department again.

Q And just because I read this in another transcript, I just need to make it a record in this case.

Doctor, you were required to withdraw a paper because of inaccurate reporting of data on a research project; is that true?

A Yes.

Q The, I think it's U.S. Department of Health, Office of Research Integrity --

A Yes.

Q -- concluded that you had falsified data, true?

A Yes.

Q And you agreed to that.

A Yes.

Q And the paper was withdrawn from publication?

A I think two figures were withdrawn, but I'm not going to -- I'm not disputing it. That's just my recollection.

Q And it was research associated with your Ph.D. dissertation?

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A Yes.

Q Was it published in a peer-reviewed journal?

A Yes.

Q And were there any other consequences to you other than the withdrawal of the paper?

A I underwent a period of monitoring, which meant subsequent to that, I agreed with the Office of Research Integrity that when I did research subsequently, I would have an extra adviser review my data.

And so during that period, I think it was two or three years, I went and did a research fellowship at New York University and had this extra layer of review and then finished that time period in good standing, and it concluded.

Q Were you required to leave your Ph.D. program?

A I had left the Ph.D. program prior to this. So the university had concluded -- basically gave me an option to redo the research and undergo a different approach, change labs maybe.

I elected to finish with a master's. So I finished with a master's in biology and moved on to medical school, but after -- this agreement with the ORI happened after I had already left the research program.

Q And do you remember generally what the topic was of the paper?

A Something with cytokines, which are kind of -- is a basic bench research project. That's about what I remember.

Q Just one other topic. You published on feasibility of treating hepatitis in jails, right?

A Yes.

Q Do you agree there are valid concerns about whether starting hepatitis C treatment in a jail population is efficacious?

A No. And the professional societies that guide us on hepatitis treatment, both of them, have made clear in the last several years that everybody with hep C, unless there's some clinical reason, everybody should be treated.

They've also moved hep C treatment into a primary care space, and so -- and they have specifically said people in jail and prison should be treated with hep C.

So I agree with those professional societies and the people who know hep C treatment, which is that being in jail shouldn't preclude you from being treated. It's a lifesaving treatment.

Q Its concern is that it needs to be continued, right? It needs to -- you need to complete the treatment, right?

MS. MAKAR: Objection to form.

THE WITNESS: I would say you could make the same argument about many other very serious problems. But, again, the professional societies that guide us on hep C treatment have said specifically, being in jail and prison shouldn't preclude you from getting treated.

So there are concerns with all sorts of treatment, but it is an anachronistic and bigoted perception that people with hep C in jail shouldn't be treated.

MR. KNOTT: Okay. I'm going to let these other folks ask questions.

EXAMINATION

BY MS. MAKAR:

Q Hi, Dr. Venters. Were there any materials you asked me for that I told you I had available to me but that I didn't make available to you?

A I don't really recall. I just recall that you shared these 26 patients with me, and I asked

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for the mortality reviews, and that's kind of all I remember.

Q Do you recall asking me for any other materials that you needed for your forming of your opinions?

A No. I think the only thing I asked for that I -- the only thing I recall asking for that wasn't available involved mortality reviews.

Q Did you notice any errors in your report while preparing for your deposition or during today's deposition?

A I think there are two. I think we already went over that I incorrectly attributed the ACH corporate policies in my list of information reviewed to a Bates number that -- so in the information review, I think there are a couple of errors, like in terms of the numbers I use, either for the ACH policies or the records for those 26 patients. I think those are Bates number errors.

And then I think there was a typo near the end of the report, where I think I used the word tracks, T-R-A-C-K-S, instead of the word lacks, L-A-C-K-S. And we already kind of discussed the -- I'm just looking it up

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right now to tell you where it is specifically. Because we already talked about this area of the report.

On page 12, there is a sentence that the second paragraph starts, "I have reviewed the ACH corporate policies, and this" -- then it says, "and this form also tracks the basic guidance." And what I meant to say -- meant to write was "lacks." And so I think I explained that when we talked about it, but that's a typo, also. I think those three are kind of the only ones I'm aware of.

Q Have you changed any of your opinions in your report?

A No.

MS. MAKAR: I don't have any further questions right now. Thank you, Doctor.

You're on mute, Andrew.

MR. JONES: The important first step in any Zoom call.

John, okay if I go next, or do you want to?

MR. CASSERLY: What's that important step you were talking about? That's fine. Go ahead.

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MR. KNOTT: I think he was saying it's important to turn on his microphone in a Zoom call.

EXAMINATION

BY MR. JONES:

Q Dr. Venters, we didn't really meet when we started. My name is Andrew Jones. I am the attorney for Monroe County and several individual Monroe County defendants.

We've been at this for a while. If you want to -- anytime you want to take a break, just let me know, okay?

A Yeah. And we have -- I think since we have, what, an hour and 20 minutes left, if we use all that time, maybe in, like, 20, 30 minutes we could take a quick break, if that's okay.

Q We've got till five o'clock your time, right?

A Right.

Q Okay. Just speak up whenever you're ready for a break.

You talked about this with Mr. Knott, but I just want to ask a few follow-up questions. And I don't intend to reask anything that he already asked -- and forgive me if I do -- but if you could take a look at

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the materials you reviewed for the purposes of your work on this file on page 4 of your report. I assume you still have that handy.

A Yes.

Q Is there anything that at this point, having answered Mr. Knott's questions, that you think that you reviewed for the purposes of your work on the file that isn't listed on page 4?

A I think that what I reference in the report, and this error I just mentioned, was that I reviewed and discussed in the report both ACH corporate policies and Monroe County policies.

And so I've cited them, you know, later on in the report, but I think that I should have put two separate headings, one for ACH corporate policies, one for Monroe County policies, and then given the correct Bates numbers for those. And I think that's an error I made. And that's the only one, I think, that I'm aware of.

Q And in terms of the medical records for Ms. Boyer, if I'm understanding this part of your report correctly, what you had available to you were medical records from the jail, the autopsy report, and her medical records from

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Gundersen Hospital after her medical event on January 23rd, correct?

A I believe so. I don't -- as I sit here, I can't recall. There's one PDF that has, like, Boyer jail records, and I think that -- and then there's another one for Gundersen, and I believe that's all I've reviewed for her.

Q And the Gundersen records were for her care at the hospital after she suffered the medical emergency in the jail, correct?

A That's my recollection. I don't recall if there was anything -- if she ever went to that hospital before, I don't recall seeing anything. I couldn't preclude it, for sure, but the records I looked at, certainly that I was concerned about, were the ones when she got to the hospital.

Q To the best of your knowledge, you did not have any medical records for Ms. Boyer from before she was booked into the Monroe County Jail in December 2019, correct?

A Not that I recall. The only qualification would be whether the ME's report referenced any prior care or care before. Sometimes the ME will do a medical history, where they put in

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some amount of, like, medical information, but I don't recall looking at medical records besides what we've just discussed.

Q And if you had looked at medical records from before her booking into the Monroe County Jail, you would have listed those on page 4 of your report, correct?

A Yeah, that would be my practice and my intent.

Q And you did not review a deposition transcript for Ms. Boyer's husband, Greg, correct?

A Not that I recall.

Q Well, there's none listed on your report. Does that indicate to you that you didn't review such a transcript?

A I don't recall reviewing such a transcript.

Q And did you review any transcripts from depositions taken of jail staff, that is security staff, other than Brooke Dempsey?

A Not that I recall, no.

Q And if you had, you would have listed them, correct?

A Yes.

Q And the patient files you list in the fourth bullet point, those are the records that had the Bates numbering starting with the prefix

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GB, GB1 through 4228. Do you see that reference?

A Yes. I think that there's a -- I have an error there, because based on the discussion earlier, I know for a fact I got a folder with 26 people in it. And so I looked at those. And so I think that I may have had an error in the number I put there, but that reflects the 26 people who I think were non-Monroe, basically, patients.

Q And that's my question to you. Those records, to your knowledge at least, were from individuals who were incarcerated in jails other than Monroe County, correct?

A Yes. I think I make that clear in the section on additional patients reviewed, or something to that effect.

Q And then am I correct in understanding, based on what's here on page 4 of your report, that you did not review any medical records for individuals incarcerated or imprisoned at the Monroe County Jail, other than for Christine Boyer, Kenneth Wilson, Jennifer Lehman, and Larry Schmieder?

A And then there's another patient --

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Q Is that Mr. Xiong?

A Yes, that's right, that's right. I think that's the total -- I think that's the total number of people for whom I reviewed records.

Q That's the total number of individuals for whom you reviewed medical records who were incarcerated in the Monroe County Jail, correct?

A Yes. Or at least at the time their records -- I reviewed the records.

Q And Mr. Schmieder, Mr. Wilson, Ms. Lehman, and Mr. Xiong, do you know why you were provided their medical records, out of all the people who were imprisoned in the Monroe County Jail between 2015 and 2020?

A I believe I would have asked if we had access to records for people who died or mortality reviews for people who died, and so I think that would be part of it.

Q Well, what would the other part of it be? If there was any other reason.

A I don't recall any other reason. I don't -- yeah, as I sit here, I don't recall how I came to get access to those records, besides the patients who died.

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Q So in response to a request for records of individuals who died, you were given the records for Mr. Wilson, Ms. Lehman, Mr. Schmieder, and Mr. Xiong?
A No. I think that -- my understanding is Ms. Lehman and Mr. Wilson died. I don't think Mr. Xiong died. I can't recall if he died or not as I sit here today.
Q And if he didn't die, do you have any understanding as to why you got his record?
A I don't recall, no.
Q But having reviewed the records for the other three, your understanding is that they were individuals who died in the jail?
A My understanding is for Mr. Wilson and Ms. Lehman -- and I kind of -- as I sit here today, I've kind of forgotten about Mr. Schmieder's case, so I don't really recall what his outcome was.
Q And do you have any other information at all about individuals other than Ms. Boyer and those four who were in the Monroe County Jail in those six years, 2015 to 2020?
MS. MAKAR: Objection. Form.
THE WITNESS: I don't believe I've

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looked at any other medical records for anybody else.
BY MR. JONES:
Q And so, for instance, do you know how many individuals were booked into the jail in those six years?
A No.
Q Have you reviewed the intake screening records for any individuals other than those five?
A No, I don't believe so.
Q Do you know how many individuals received medical care in the Monroe County Jail in those six years?
A No.
Q Do you have any idea or do you have any knowledge as to how many prisoners in the jail were suffering from withdrawal from drugs or alcohol in those six years?
A No.
Q Do you have any knowledge as to how many of those were placed on withdrawal protocols, such as CIWA or COWS?
A No.
Q Do you have any knowledge as to how many prisoners in the Monroe County Jail suffered

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medical emergencies in those six years?
A No.
Q Do you have any knowledge as to how many prisoners in the jail were referred to outside medical care during those six years?
A No.
Q So if we look at -- if we could turn to page 12 of your report. Are you there? Or let me know when you are.
A Yes.
Q So in this section of your report about your findings and opinions with respect to Ms. Boyer's death, there are several opinions you offer, each one under a separate heading, correct?
A Yes.
Q And the first one, starting on page 12, has to do with your opinion with respect to the adequacy of the intake screening or medical clearance, correct?
A Yes.
Q And if we just identify the individuals who were jailed at the Monroe County Jail for whom you reviewed records, that fall -- strike that.
My understanding on reviewing your

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report is that there were two patients, two individuals who were in the jail for whom you reviewed their records, that form the basis for this opinion. Is that correct? That is Ms. Boyer and Mr. Schmieder.
MS. MAKAR: Objection. Form.
THE WITNESS: I would -- looking at this section here, it references the individual records for people, but it also references, for instance, the deposition testimony of staff.
So, for instance, there's a paragraph that starts on page 13, "Nurse Practitioner Pisney testified that she had never seen one of the intake sheets before the death of Ms. Boyer."
BY MR. JONES:
Q So let me rephrase the question, just so we're talking about the same thing.
If we were to identify the individuals who were imprisoned at the Monroe County Jail whose records you reviewed and formed at least part of the basis for this opinion, it's two individuals, Christine Boyer and Larry Schmieder, correct?
A Yes. Those are the two people that I cite for

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medical records.
Q And then on page 17 of your report, you move on to discuss an opinion with respect to monitoring of individuals for substance withdrawal, correct?
A Yes.
Q And if we create a list of the individuals imprisoned in the Monroe County Jail for whom you reviewed their records that fall within this opinion, that's three individuals, correct? Ms. Boyer, Jennifer Lehman, and Kenneth Wilson?
A Yes.
Q No others, correct?
A Correct.
Q And if we look at page 20, you move there to a discussion of an opinion you hold with respect to the response to medical emergencies, correct?
A Yes.
Q And so for that section of your report, that opinion, in terms of the individual -- individuals who were imprisoned in the Monroe County Jail whose records you reviewed that form a part or a basis for that opinion, it's

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Ms. Boyer and Mr. Xiong, correct?
A Yes.
Q No others, correct?
A Correct.
Q And then finally, starting on page 24, pages 24 through 26, you're offering an opinion about failure of ACH to conduct mortality reviews, correct?
A Yes.
Q And same question. The individuals who were imprisoned in the Monroe County Jail for whom you reviewed records that form the basis for that opinion, it's two, Ms. Boyer and Mr. Xiong, correct?
MS. MAKAR: Objection. Form.
THE WITNESS: Well, my understanding is nobody got mortality reviews. So the patients who committed suicide, my understanding is they didn't get a mortality review. But I think that, essentially, the denominator is everybody who died, and the numerator is zero, because I didn't -- I didn't see any mortality reviews.
BY MR. JONES:
Q And you don't know how many people died in the

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Monroe County Jail in the five years prior to Ms. Boyer's death, do you?
A Not as I sit here today, no.
Q Well, do you believe you have any information in your report that would answer that question?
A Well, I referenced a couple of deaths -- I don't know if it was five or seven years before -- but to answer your initial question, I've seen zero mortality reviews.
So for Ms. Boyer, for Ms. Lehman, for the other person that committed suicide, that's three, I don't know what the time span is, but I haven't seen any mortality reviews.
Q And the individuals that you cite in your report as a basis for your opinion about mortality reviews who were incarcerated in the Monroe County Jail, that's Ms. Boyer and Mr. Xiong, correct?
A Well, I think that Mr. Xiong is an example of a problem that would have been fixed with mortality reviews. He didn't die, but I think he's a good example of either morbidity or critical case review.
But my understanding is there are three people who died, Ms. Boyer, Mr. -- sorry,

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I'm blanking on the other two names, the two people who died by suicide.
So those are, at a minimum, three people that should have had mortality reviews that I didn't see any for.
Q And in that answer, you're talking about Ms. Boyer, Ms. Lehman, and Mr. Wilson, yes?
A I think so, yes.
Q Would you look at page 13 of your report?
A I'm sorry, did you say 13, one three?
Q Yes. Bottom of 13 onto 14. You have a discussion there of elements missing from the intake medical screen form that you saw --
A Yes.
Q -- and used in Ms. Boyer's case?
A Yes.
Q And you indicate that the form was missing many of the basic elements that the NCCHC standard indicates should be part of the form, yes?
A Yes.
Q And that's NCCHC J-E-02, is it not?
A It may be, as I sit here. I'm not disputing it. I just don't recall or have the standard in front of me.
Q And you were quoting there at the bottom of 13

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to the top of 14 your -- what you were doing there was repeating portions of that standard that should be in the intake screening form, correct?

A Yes. Or, like, very -- it doesn't have to -- I don't take the position that it has to be exactly those words, but, you know, disability accommodation, history of withdrawal, these broad areas should be part of every receiving screening.

Q And just looking at that block quote from the bottom of 13 onto the top of 14, what specifically was missing from the form used with Ms. Boyer?

A Well, we've already talked about one of the areas that I think is relevant to the case, which is the history of withdrawal. It's not even clinically useful to ask a patient who's intoxicated are you withdrawing.

There are very specific and standard questions about the history of withdrawal the jails everywhere I've been asked. So have you ever experienced -- what happens when you stop drinking? Well, a lot of patients don't even know what withdrawal is, so you're asking them

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a question that's impossible or hard for them to answer.

So the standard approach that I've seen in jails all over the country is, what happens when you stop drinking? How do you feel? And then affirmatively they ask, do you ever get the shakes? Do you ever get dizzy? Do you ever see things? All these things that go into a history of withdrawal. So that's an example that it's relevant to my second finding in this case.

By the way, you also see, you know, I think that asking about -- getting a good set of vitals, asking about some of these other problems, like dental problems or accommodation for -- or need for disability accommodation, that's important, but the one that's most directly relevant that seems to be missing from the intake screening form that I looked at is the withdrawal history.

Q Okay. In addition to that element, what else were you referring to when you said the form was missing many of the basic elements?

A Well, pregnancy history, recent pregnancy. I mean, that's -- as I said before, I have never

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encountered a jail that doesn't ask about or test for, through a urine dip or some -- you know, doesn't try and figure out if a woman coming into the jail is pregnant. It's just really unheard of.

Q So other than history of withdrawal and pregnancy, what other basic elements were missing from the form?

A Well, I mentioned various -- there's several types of disability and accommodation for disability. And I haven't -- I didn't create a side-by-side list, but it would be easy to pull up -- because there are quite a few missing things, it would be easy to pull up that form and then compare it right now to this.

Q Well, whatever you need to do to answer the question, but you offered the opinion that the form was missing many of the basic elements, and I just want to know from you what the basic elements are that were missing.

MS. MAKAR: Objection. Form.

THE WITNESS: I've just offered multiple examples.

BY MR. JONES:

Q I'm asking for a complete list.

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MS. MAKAR: Objection. Form.

THE WITNESS: As I sit here today, I'm not in a position to create a spreadsheet or a list, but if you'd like me to provide it and cross-reference what's on that form with what's in this list, I'd be happy to.

BY MR. JONES:

Q Really, all I'm asking for, Doctor, is if you can tell me what you meant when you wrote in your report that the form was missing many of the basic elements.

If you're able to, please do; if you're not, please tell me.

MS. MAKAR: Objection. Form.

THE WITNESS: Okay. I don't have your intake screening form memorized. So if you'd like to bring it up, and I'll tell you specifically.

BY MR. JONES:

Q Are you able to answer the question in any other way?

A Not without -- I've given you multiple examples of what you just asked for. To give you more definitive examples or the complete list of the examples, I simply need to compare the intake

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screening to this piece of paper. And we could have accomplished this in a tenth of the time we're talking about it if you just put it up on the screen.

MS. MAKAR: I need a break in the next couple minutes, Andrew.

MR. JONES: We can take a break now, if you'd like.

MS. MAKAR: Thanks.

MR. JONES: How long do you want, Maria?

MS. MAKAR: Ten minutes.

MR. JONES: Okay. 2:50.

(A recess was taken from 2:40 p.m. to 2:50 p.m.)

MR. JONES: Okay. Back on the record.

BY MR. JONES:

Q Doctor, I think this might be one thing that Mr. Knott asked you, so forgive me in advance, but the NCCHC standard relating to intake screening, does it speak to taking vital signs or not? Do you know?

A I don't recall -- I don't recall as I sit here today.

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Q If it doesn't, is there another NCCHC standard that you're aware of that speaks to the requirement to take vitals at intake?

A Usually -- I would have to review, but I think there's -- in the stand -- in the approach where custody staff do the -- just ask a few questions or ask a bunch of questions, then there's usually an approach that involves a nurse assessment after that.

And so I think in that two-step, when it's not a nurse seeing the patient first, when it's custody staff, then a nurse, I think that would -- either way, the patient should have their vitals on the way in. I just don't recall if that's -- where that's in, this standard or the one that follows.

Q And, again, sticking with NCCHC standards, are you aware of what NCCHC standard, if there is one, that requires that a pregnancy test be done on a female prisoner of childbearing age?

A I don't recall. I think there's mention of pregnancy history has to be collected, which obviously was not done in this case. And I don't recall where the pregnancy test is. It may be like the vital signs is done by nursing

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staff right after the custody staff, but I don't -- as I sit here today, the J-E-02 specifically mentions pregnancy history, which was not collected. The test itself, I don't recall where it's referenced in the standards.

Q You're not able to tell us what standard would include that requirement; is that correct?

A No, not as I sit here today.

Q And what does the standard of care in correctional health, in your opinion, require if a patient or inmate declines assessment by a health care provider?

A Well, if it's the initial assessment, the standard of care involves -- it depends on whether or not they're going to answer questions, and you can rule out communicable disease concerns.

So, for instance, some of the questions that are lacking from this form that you all used and this NCCHC specifically references involved the concern for potentially having tuberculosis. So asking things like are you spitting up blood at night? Have you had weight loss?

Every correctional setting worries

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about tuberculosis, other communicable diseases coming in and causing an outbreak. So when a patient won't answer any of those questions and the health staff and the security staff can't figure it out, then often those patients will go into a medical isolation cell. And there are various approaches to figuring that out.

That's separate from if the patient has a potentially life-threatening emergency. If the patient won't agree to an assessment, but it looks like they're in distress, then they would be sent to the hospital.

Q Well, what about -- what about a patient or a detainee who does not appear to be in any sort of medically emergent state, but declines a medical assessment by health care staff? What does the standard of care require in that instance, if anything?

A Well, it kind of comes down to the clinical risk. If a patient, for instance, is severely -- is intoxicated, where they're -- this is pretty common in jail settings -- patients come in, they're intoxicated, they either can't or won't engage with health staff, then those patients go out for medical

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clearance, where they go to a hospital, the hospital makes an assessment, and then they come back.

The same could be true for a patient with a, you know, psychiatric problem. When they're not engaging with health staff, it's not actually clear to custodial or health staff what the problem is. The patients often don't engage.

And so what we don't want is for them to say, we'll see you in 24 hours, or we're just going to peek in the cell every, you know, half hour. We want to know if there's any concern about withdrawal, psychosis, suicidality, those patients to get assessed and medically cleared.

Q So let's take it out of the intake context. And so if it's just a detainee who's already in custody and has been in custody for some period of time and is not presenting with withdrawal or any concern of a risk for contagious disease and is not presenting with any sort of emergent condition and that individual declines, say, an H&P, that sort of assessment, what, if anything, does the standard of care require for

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staff in that instance, in your opinion?

MS. MAKAR: Objection. Form. Incomplete hypothetical.

THE WITNESS: So there's two kind of interests at play. One is patients who are incarcerated or detained, they retain decisional capacity. So this is a core element of -- there's a basic medical ethic principle that says people have the right to make decisions about their health care.

So if a person is refusing something about an assessment or care, a provider, which is, you know, an M.D., a P.A., or a nurse practitioner, needs to assess their decisional capacity.

There is another interest at play, though, which is that if any of this assessment relates to the safety or health of people around the person.

So I mentioned communicable disease. An example I've run into is, you know, if there's an outbreak of MRSA, methicillin resistant -- or you know what, I'll just say if there's a -- if there's an outbreak of a skin infection, it could spread to other people.

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If a patient refuses to be assessed by that, they may retain the decisional capacity to refuse that assessment, but it may be that there's an important response that involves physically separating them from other people so that doesn't spread.

So those are my two practices and I think won't reflect the standard of care for refusal of different elements of assessment.

BY MR. JONES:

Q So if a detainee or a prisoner declines an H&P, and there isn't a concern about that prisoner's capacity to make that decision, and there isn't a concern about the sort of health risk to others that you described in your example, what does the standard of care require in that instance?

A Well, I'm not really familiar with patients who persistently refuse their initial history and physical. I think that my experience in doing history and physicals is that a patient may refuse it on day one or two, and, you know, it's the job of the health staff, the doctor or the nurse practitioner or the physician assistant, to try and engage with them to get

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it done.

And sometimes it might mean negotiating, getting the most critical parts of the medical history or the physical exam, but certainly engaging with a patient to try and get the essential parts of the history and physical done, that's the obligation of the health staff.

Q And ultimately, does the individual who's detained retain the authority, the ability to say no, I decline for that sort of assessment, as long as they're considered to be capable of making that decision?

MS. MAKAR: Objection. Form.

THE WITNESS: And as long as there's no concern about a communicable disease. I think -- I actually have not encountered that ever in my career. Sometimes people refuse things, but they generally will agree, you know, on day two or three or four.

BY MR. JONES:

Q I don't mean to ask you based solely on your experience. My question is, as someone who's practiced in this field, in your opinion, do individuals retain the right to decline

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assessment by medical staff, as long as they're capable of making that decision and don't present a risk of the sort of contagious disease that you've described in your prior responses?

MS. MAKAR: Objection. Incomplete hypothetical.

THE WITNESS: I think if you check off the box of doing a decisional capacity assessment, and you've tried to engage with a patient, and there's no concern with any communicable diseases, then it is foreseeable, but depending on the type of facility, it is often the case that those patients will be in a medical isolation cell. Because I just have never -- it's such a rare, in my experience, impossible -- or I haven't encountered it -- hypothetical, that once a patient is in medical isolation and staff are engaging with them, they're able to get the information they need and do the assessment they need within a few days.

BY MR. JONES:

Q In terms of Ms. Boyer, do you know anything about her use or abuse of alcohol, opiates,

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and/or benzodiazepines before she was booked into the jail?

A No, I don't think so.

Q And to your knowledge, was she documented as a daily alcohol drinker?

A I would have to review the intake assessment. I don't recall -- I don't recall that.

Q You don't know one way or the other?

A As I sit here today, I don't recall.

Q And I know you discussed this in part with Mr. Knott, but just to be sure I understand your opinion, all else being equal, would you expect an individual who consumes alcohol, on average, three times a week, but not to excess, to experience alcohol withdrawal symptoms if they don't have a drink for 24 to 36 hours?

MS. MAKAR: Objection to form. Improper hypothetical.

THE WITNESS: I would -- that's a little bit more precise question, and I think that when people drink two or three times a week consistently, when they stop drinking, they'll have withdrawal symptoms. They may be mild, but they may not, and it depends a little bit on them, a little bit on their other health

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problems.

But, you know, we have to look for withdrawal, otherwise we miss it, and withdrawal can be missed and can be very serious in patients who we don't think drink as -- you know, to excess, or get drunk falling down.

So, yes, in that scenario you just postulated, that patient certainly, I would suspect, will feel some symptoms of withdrawal. It depends if there's other withdrawal or other health problems, but yes, I would predict some symptoms.

BY MR. JONES:

Q To be sure that I understand, your medical opinion is that someone who has a drink or two three times a week, but not to excess, will experience withdrawal if they don't have a drink for 24 to 36 hours?

A I think it's very possible that a person who has multiple drinks multiple times a week will experience some sort of withdrawal. And I think, as I said, if they have heart problems, lung problems, if they're also taking anything else that they could withdraw from, then the

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likelihood of those would be exacerbated.

But it is not the -- we don't know when a person comes through the door the truth of how much they drink, and one of the problems with this form you have and the facility is it asks specifically do you abuse drugs or alcohol. And that is such an antiquated, harmful way to ask the question, because patients don't respond to that. Patients -- the standard of care in corrections for a long time has been to simply ask do you use alcohol, do you use drugs. So when you start with this question do you abuse, it makes a moral judgment on the patient, and it really sets you up to not find out if it's one drink or five drinks a few times a week.

Q So it's possible that someone who drinks three times a week but not to excess would experience withdrawal symptoms if they don't have a drink for 24 to 36 hours? Is that your testimony?

MS. MAKAR: Objection. Form.

THE WITNESS: Yes. And, you know, alcohol withdrawal symptoms can occur over a period of days. And as I said, also, one of the important modifiers about that would be if

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there's any withdrawal from other substances or other health problems.
BY MR. JONES:
Q On page 20 of your report, you indicate that the Gundersen Health -- or excuse me, Gundersen Hospital records for Ms. Boyer confirmed the presence of benzodiazepines in her system on the day of her admission, so January 23rd.
Do you see that reference, end of the paragraph that carries on to page 20?
A I'm looking. Sorry, I'm having trouble finding it.
Q On page 20 of your report.
A Okay. Sorry. From 19 to 20. I was looking at 20 to 21.
Q Sorry. The last sentence of the paragraph that carries on to page 20.
A Yes, I see that.
Q Okay. So what's the significance for your opinion with respect to Ms. Boyer and the possibility of her experiencing withdrawal symptoms of the fact that she had benzodiazepines in her system when she first got to Gundersen?
A I'm not sure. I think that the most important

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thing is that, as I recall, she had a benzodiazepine pill in her purse, that that should have triggered the withdrawal monitoring. That she had benzodiazepines in her system later, either when she died or when she was at the hospital, as I said earlier, I don't have a definitive opinion that she was for sure in one type of withdrawal or another. So I would say that is just kind of a recitation of -- that she had benzos in her system.
The most -- in terms of the deficiency in the care, that second finding is that there was a concern that she had some benzodiazepine on her person, and that should have triggered, although it would have been probably the same tool, monitoring for withdrawal symptoms.
Q And does the fact that she had benzodiazepines in her system when she was admitted to Gundersen on January -- excuse me, December 23rd, does that say anything about whether or not she was in withdrawal?
A Well, no. We don't know anything about if she was in withdrawal, because it was never

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measured.
That's the point I keep coming back to. If you don't look for it, then you get to say it never happened, because you never found it. But she needed withdrawal monitoring. I don't have an opinion that she was definitely in this type of withdrawal or that type of withdrawal.
Q Are there short-term versus long-term diazepines -- benzodiazepines?
A Sure.
Q And what's the distinction there?
A Well, clinically, the difference is the mechanism of action, how long it lasts. From a jail health standpoint, when you do a withdrawal assessment, when you start the CIWA -- you usually would use a CIWA for alcohol and benzodiazepine -- if you learn that a person was on a long-acting benzodiazepine, then you may want to extend out your period of monitoring. But in terms of the initial days in the jail, it's not -- you would just start the withdrawal monitoring right away.
Q In your experience, does whether someone is using a long-acting benzodiazepine versus a

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short-acting benzodiazepine have any impact on how quickly they'll begin to feel withdrawal symptoms?
A Sure. The American Society of Addiction Medicine has all sorts of tables that lay this out, but basically, we think of most withdrawal symptoms happening in the first few days in a jail. There are people that have been taking long-acting benzodiazepines that could show up with their most serious symptoms, let's say a week or even up to ten days into incarceration.
And so those assessments and decisions are really important later on, not so much in the first couple of days you would start, you know, the CIWA monitoring, but it could be relevant, let's say, a week into or five or six days into detention, where, you know, the concern about alcohol or short-acting benzo withdrawal has waned, but if you knew that they were on a long-acting benzodiazepine, you might continue monitoring.
Q If Ms. Boyer had been abusing opiates, would you have expected -- or would you expect opiates to have been found in her system at Gundersen?

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A I think -- well, I would think if she had -- if she had a tox. screen done, the opiates would have been found, so yes. And I don't recall seeing that she had any opiates in her system. But, yes, generally, whether it's prescribed or illicit opiates, whether it's pills or other forms, they would show up in most tox. screens.

Q If she had been using them regularly or abusing them, they would have shown up in a tox. screen done at Gundersen when she first got there.

A I think so, yes.

Q Is there -- on this subject of withdrawal assessment, I don't think I saw in your report a specific cite, such as to an NCCHC standard with respect to your opinion that the basic standard of care required that Ms. Boyer had been assessed and monitored for withdrawal.

Is there a specific standard that you can point us to?

MS. MAKAR: Objection to form.

THE WITNESS: Yeah. I think there's a -- NCCHC jail standards have a withdrawal -- medical management and withdrawal standard, I can't remember what the number is, and I think since at least 2014, they've referenced one --

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using one of the accepted tools, meaning CIWA or COWS. And I'm happy to go look at what that standard is, but I'm pretty sure it's management or medical management of withdrawal.

BY MR. JONES:

Q The policy -- the policy that you describe -- the jail policy that you describe on page 18 of your report, with respect to intoxication and withdrawal, that written policy -- let me know when you're there.

A Yes, I see that.

Q Do you have any concern with respect to the policy as it's written?

A I don't recall as I sit here today. I think that's the policy I was just thinking of when you asked me the prior question. As I sit here, I don't recall whether or not the Monroe County policy has what I believe is in the NCCHC standard, which is to mandate that people are monitored on a regular basis for withdrawal. And so I think that that's probably the most important element of medical management and withdrawal is the monitoring via these tools.

And so if that was not in the policy

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that Monroe County had or they had not worked to ensure that their vendor had that approach, that would be a critique.

Q Are you expressing an opinion in your report that the written policy, as you quoted it on page 18 of your report, is deficient in some way?

A I'm -- no, because I think that it is my experience that sometimes counties may have a medical policy that doesn't spell out every element of care that should be provided. And so I think it's important to ensure for this exam -- because this is a common cause of preventable deaths in jails, the county should have a way to ensure that this part of the clinical standard of care is followed. Often they copy and paste the whole NCCHC standard in, but certainly some counties also take the approach of having a more minimal set of clinical standards, but then making sure through oversight or quality assurance that the vendor does meet the clinical standard of care. So there are different ways to do that.

Q Well, again, I'm just trying to understand if you're expressing an opinion one way or the

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other as to whether the written policy that the county had in place was deficient.

A And I'm saying I don't recall as I sit here today, and so I'm not making an opinion today about this area where I have identified what I think is a clinical deficiency in the ACH approach as to whether or not that reflected a deficiency on the county's side.

Because I would allow for the fact that counties can use written policies, but they can also use other means to ensure that a vendor meets clinical standards of care.

Q In terms of mortality reviews, I think Mr. -- when Mr. Knott was asking you questions, you talked about the fact that NCCHC has a standard relating to the procedure in the event of an inmate death.

And so setting that aside, is there an NCCHC standard that requires the sort of after-the-fact review by the medical care provider in the event of serious events that don't lead to death?

A I think there are two places where the NCCHC talks about it. One is in the clinical quality committee, and one is in suicide prevention.

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Those are two areas where patients think they happen, where the patient doesn't die or worry about the adequacy of care.

Q And so if we look for the NCCHC standards about CQI and suicide prevention, that's where we'd find reference to that kind of after-the-fact review?

A That's my recollection as I sit here today.

Q Okay. Is there any other -- or are there any other standards that you would point us to on that requirement?

A Well, the standard of care in corrections, based on my experience, is that the M&M process is just that, it's morbidity and mortality. So the NCCHC limits -- has a very limited scope, but my experience in jail and prison settings, as a federal monitor, for instance, is that these reviews, these types of reviews, often occur after a critical incident that doesn't involve death.

Q And what would the parameters be for deciding what sort of events require that kind of review outside of a death?

A Well, it requires that the clinical leadership, the medical director of the facility or the

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nursing director, somebody identify a case where there was a deficiency that needs addressing or that could happen again.

So on the mental health side, it's often self-harm or, you know, suicide attempt, which are two different things. Missed medications or wrong medications are examples.

So there are -- it's fairly broad, and it requires that the clinical staff have some instruction on when and how to do this.

Q Do you recall in your review of the records from Mr. Schmieder's death that there was an investigation into that death done by the Monroe County Sheriff's Office?

A I don't -- as I sit here, I don't recall that. But what I'm talking about is a clinical review by clinical staff.

Q I understand the distinction. I just wanted to confirm if you know whether or not the records that you reviewed relating to Mr. Schmieder did incorporate an investigation done by the county.

A I'm not disputing it. I just don't happen to recall that fact.

Q And same question as to Ms. Lehman.

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A Yes, again, same. My -- I don't -- I testified considerably up to this point about the lack of clinical mortality reviews, but I'm not disputing the existence of other types of either critical incident reviews or administrative reviews.

Q You talked quite a bit today about -- well, strike that.

There are places in your report with respect to your opinions that you refer to various NCCHC standards set out in their standards for health services in jails.

I understood from Mr. Knott's questions of you this morning that in addition to those NCCHC standards, there are instances where your opinions are based on your general view of the standard of care based on your experience in the field. Is that a fair statement?

A Yes.

Q And so in those instances where in your report for your opinions, you don't cite to a particular NCCHC standard, are those instances where you're offering opinion about the standard of care based on your experience

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generally in the field?

A Yes.

Q And so in those instances, what you're telling us is based on your general training, experience, and knowledge, you have an opinion about the standard of care. Is that a fair statement?

MS. MAKAR: Objection. Form.

THE WITNESS: Yes.

BY MR. JONES:

Q But in those instances, you're not -- where you don't cite to the NCCHC standards, you're not pointing to anything more specific than just your general experience and knowledge and training, correct?

A I think so. I mean, I was just asked about hepatitis C. So it wasn't in my report, but there are clear recommendations by professional societies that are clinical about the need to treat hepatitis C in jails and prisons.

And so I think I also mentioned earlier in this discussion about standards that there are lots of clinical standards, in fact most clinical standards, of care that the NCCHC does not reference or get into.

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And so the discussion about peak flows, I didn't put it in my report. It's my longstanding interpretation of the clinical standard of care that when a patient is seen who has asthma, their peak flow should be checked. That's a clinical standard of care. That also happens to be supported by the CDC and the professional societies that treat asthma, but the difference is that the clinical standards of care are often not dealt with by the NCCHC, which is dealing more with the jail process standards.

Q Really what I'm getting at is those instances in your report where you don't cite to a specific NCCHC standard for a particular opinion about standard of care, are those instances where we can understand that what you're relying on is your general experience, knowledge, and training as a physician in the field?

MS. MAKAR: Objection. Form.

THE WITNESS: Yes, I think that that's fair.

BY MR. JONES:

Q The invoice that you supplied to Ms. Makar for your work, that invoice was current as of the day you signed this report, correct?

A Or when I sent the invoice, which might have been the same. I don't -- there would be a date that the invoice was sent. So, I mean, my practice would normally be to send an invoice a day or two after the report, so probably that's true.

Q So the invoice would reflect all of the time you spent on the file up through and including the date of the invoice, correct?

A Yes.

Q And do you keep track separately of the time you spend on a file?

A I usually will have an invoice open. And so I think I have an invoice number two open, where I just jot in a Word document the number of hours that I've put in. And then I'll close that out and send that whenever I'm ready for a subsequent invoice. So I guess that is kind of a separate approach.

Q But for the time you spent that was reflected in the first invoice, the only invoice, as I understand it, that you sent to Ms. Makar, there wouldn't be any separate record of the time you spent on the file and how you spent that time, or would there?

A No, you're correct.

Q Do you recall when you were retained to work on this file?

A No. I think it would have been in the latter part of 2024, but I don't recall when.

Q Can you give us anything more specific beyond latter part of 2024?

A I think the last four months, maybe.

Q The fall of 2024?

A Sometime in the last four months. I just don't recall.

Q And other than speaking with Ms. Makar, was there anything else you did to prepare for the deposition today?

A I reviewed my report, so I reread my report, and I re -- I believe I reread Ms. Boyer's medical records. And so aside from just looking at records, I didn't speak with anybody else or do anything else.

Q How much time did you spend preparing for the deposition outside of your meeting with Ms. Makar?

A I think three or four hours.

Q And how long was the meeting with Ms. Makar?

A I believe it was one hour.

Q Is there anything else specific you recall reviewing other than your report and Ms. Boyer's medical records in the three to four hours you spent preparing outside of the meeting with Ms. Makar?

A Not that I recall.

Q I understand that Ms. Makar or her office sent you various records to review, correct?

A Yes.

Q And my understanding, based on your testimony thus far is you would get an email that wouldn't have any substantive text, and it would contain a link to whatever additional records you were being provided. Is that correct?

A As I sit here today, I actually don't know if it was a Box link. That's most commonly how I get records. It could be that they were just sent as email attachments, which would be pretty burdensome with this case. But either way -- as I sit here today, I don't recall that, because either way, what I would be doing is downloading a file, either from an email or

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from a Box link that came with a report -- or came from counsel.

Q Were there any communications in writing from Ms. Makar or her office that in the communication identified any facts or data provided by her or her office that you relied on in forming your opinions?

A No.

Q Were there any communications from Ms. Makar or her office that provided assumptions for you to rely on in forming your opinions?

A No.

Q And were there any communications to and from Ms. Makar or her office relating to your compensation for your work on the file other than the one invoice you've provided to date?

A No.

Q And the hourly rate that you're charging for your work in this file, is it your standard rate, or is it higher or lower than your standard rate?

A That's my standard rate.

Q You are not a cardiologist, correct?

A Correct.

Q You are not an emergency room physician,

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correct?

A Correct.

Q You are not an addiction medicine specialist; is that correct?

A Correct.

Q Are you a fellow or member of the American College of Correctional Physicians?

A No.

Q Have you ever been?

A No.

Q Have you ever worked in a jail setting in a capacity other than as a medical professional?

A Other than as a monitor or -- so including monitoring a jail and also working directly as a medical professional, no, no other roles.

Q And your monitoring role, that's as a physician, correct?

A Yes.

Q So you haven't been a corrections officer, sergeant, lieutenant, any sort of security role in a jail.

A Correct.

Q Have you ever received any training as a security officer in a jail or other confinement setting?

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A No.

Q You are not an expert on the security aspects of corrections, correct?

A No. With the narrow carve-out that there is a part of security training that is generally referred to as health training for correctional staff. And so both in my role in the New York City jails and my role as a monitor, I have expressed expertise and authority in contributing to and reviewing those policies.

So as a monitor, I look at what health training is given the security staff, for instance, and what they're advised or trained to do. But with that very narrow carve-out, which would include suicide prevention, I have no other expertise in security matters.

Q What did you do between 1989 and when you began medical school, which, if I'm interpreting your CV correctly, was 1999?

A I was in the Peace Corps in West Africa. Then I came back and took several years to take basic science classes to apply to medical school. I worked as an EMT while I was doing that. And then I went to Illinois and started

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working in a lab and then transitioned to medical school.

Q So when was the Ph.D. work that Mr. Knott was asking you about?

A I think that was maybe 1999 or 2000. It was right at the time when I was starting to become a medical student.

Q Are all of the specific sources that you relied on in forming your opinions cited in your report?

A Yes, with the caveat that I identified, I think, two errors in the information reviewed regarding the Bates numbers in reference to ACH corporate policies and Monroe County policies. But with that exception, I believe everything I reviewed upon -- everything I've relied upon for my opinions is included in the report.

Q And it's a problem with the wording of the question, but what I was meaning to ask you about was, you know, for instance, various NCCHC standards, sources like that.

Are all of the sources in your field of work that you relied on in forming your opinions, are those referenced or cited in your report?

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A I believe so, yes.

MR. JONES: Okay. I think that's all I have, but I'll turn it over to Mr. Casserly, and if I think of anything else, I'll ask it at the very end. Thank you, Doctor.

THE WITNESS: Thank you.

EXAMINATION

BY MR. CASSERLY:

Q Good afternoon, Doctor. My name is John -- excuse me -- my name is John Casserly, and I represent a corporation called USA Medical and Psychological Staffing, as well as some past and one current shareholder of that corporation. Their names are Drs. Johnson, Schamber, Harmston, and Bresnahan.

Have you reviewed the -- I don't expect to take a lot of time with you unless you surprise me with some opinions that aren't in your report or documents that aren't listed as having been reviewed. I just need to dot my I's and cross my T's. So I hope to be done with you in 10 or 15 minutes here.

Depositions were taken of founder and shareholder Dr. Johnson, CEO of ACH; Jessica Young; and CFO of ACH, Jaime Lynch.

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Have you reviewed those deposition transcripts?

A Not that I recall.

Q Okay. Have you reviewed the deposition transcript of plaintiff's previously disclosed expert, Jeffrey Keller?

A No.

Q Have you discussed with Ms. Makar whether you would be providing opinions about whether there was any inappropriate conduct by the shareholders or corporate governing bodies, not regarding health policies, but regarding corporate operations? Was that topic discussed between you and Ms. Makar?

A I think it's safe to say no. I'm not even sure what that means, but I don't recall any discussions in that area.

Q Okay. I'll walk you through a bunch of examples of things that I'm referring to, and then I'll come back at the end and follow up on that question, because that was a fair criticism of it.

In your review and preparation of opinions in this matter, have you evaluated and come to an expert opinion about whether ACH has

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engaged in inadequate capitalization of the business?

A No.

Q Have you -- the same question, have you developed an opinion about whether or not ACH has ever failed to observe corporate formalities?

A No.

Q Have you developed an opinion about whether ACH has failed to issue stock?

A No.

Q Have you developed an opinion about whether ACH has failed to make dividend payments?

A No.

Q Have you developed an opinion about whether ACH has overlooked and permitted nonfunctioning of any corporate officers or directors?

A No.

Q Do you have the opinion that ACH has engaged in not creating or losing corporate records?

A No.

Q Have you developed an opinion that ACH has been engaged in permitting the insolvency of any debtor corporations?

A No.

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Q Have you come to the opinion that ACH has engaged in inappropriate commingling of funds?

A No.

Q Have you come to the opinion that ACH has engaged in diversion of assets from the corporation to a shareholder or other person, to the detriment of creditors?

A No.

Q Have you got the opinion that ACH has failed to maintain arm's-length relationships among its related entities?

A No.

Q Do you have the opinion about whether ACH is a mere facade for the operation of dominant shareholders?

A No. And I don't believe I understand what that means, but I have no opinions that even come close to that.

Q Okay. There is a separate corporation from ACH that I mentioned I represent, and that is USA Medical and Psychological Staffing, S.C. That's a Wisconsin corporation. And so I'm also going to ask you only three questions, but they're a little wordier under Wisconsin law.

Do you have an opinion that any

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shareholders of USA Medical -- I'm going to shorten it to USA Medical -- is engaging in complete domination of finances, policies, and business practice in relation to the provision of medical care?

A No.

Q Do you have an opinion that -- well, actually, these are series -- these are series elements, so because you don't have that opinion about the first element, I can relinquish the rest of my time. I have no other questions, Doctor. Thank you.

A Thank you.

MR. KNOTT: Doctor, I'm sorry, but I have a couple more topics to follow up. I understand we're running out of time. I'll try to be brief.

EXAMINATION

BY MR. KNOTT:

Q Is it fair to say that chest pain is frequently reported by patients who do not have a cardiac issue?

MS. MAKAR: Objection. Form. Improper hypothetical.

THE WITNESS: Yes, that occurs.

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BY MR. KNOTT:

Q It's a very difficult thing for providers working in jails to deal with, isn't it?

MS. MAKAR: Objection. Form.

THE WITNESS: I'm not sure what you mean by "difficult." I think it's a common presentation or complaint by patients, and it can be difficult if we go through all the steps that we should and then the patient comes back. But it's one of the more easily protocolized potential medical emergencies in jails.

BY MR. KNOTT:

Q Have you ever seen any statistics about what percentage of chest pain presenting in emergency rooms and urgent cares is of noncardiac origin?

A Not that I recall sitting here today.

Q And I want to ask you about the source of your standard of care with respect to some of this.

You testified that testing of women of childbearing years is absolutely fundamental and part of the standard of care.

Is that a fair characterization of your belief about this?

A Yes.

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Q And you believe it's a breach of the standard of care of a reasonable jail medical provider and jail if they do not test women for pregnancy, right?

A Yes. They -- the fact is, there may be people that are pregnant or report being pregnant, but pregnancy status and pregnancy history should be assessed for every female patient of childbearing age.

Q And I think you said it was unheard of that a jail would not test. Is that your opinion?

A Well, I'm not saying I've never seen it missed. I just haven't encountered jails that don't do this, that don't get pregnancy history and pregnancy status for women coming in the front door.

Q You feel very strongly that it is a widespread protocol to test for pregnancy in women coming into jails.

A Well, as I just said --

MS. MAKAR: Objection. Form.

THE WITNESS: -- assessing pregnancy status and pregnancy history I believe is a standard of care. I don't -- I'm not sure I've --

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BY MR. KNOTT:

Q No. I'm talking about pregnancy tests. I'm trying to make this short. I don't -- I'm talking about not treatment of pregnancy. I'm talking about just getting a pregnancy test in people who don't know whether they're pregnant or not, and that's what I --

A I think that's a standard of care.

Q And what would you -- what would you estimate is the percentage of jails nationwide that have protocol for testing every woman of childbearing years?

A I don't know.

Q And the reason I'm asking this is because what can we refer to as the source of your standard of care in regard to that opinion?

A I would give my opinion as a medical expert based on my experience in correctional health. I just haven't -- this is the first discussion I think I've ever had where people are questioning the need to identify who's pregnant and who's not for women -- it's like a tuberculosis test. I've just never encountered people say or put forward the opinion that's not something we have to know.

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Q Do you review or regularly receive the American Journal of Public Health?
A It's been some time since I've received it.
Q Am I correct in understanding that the standard of care does not require a mortality review of a death in a jail if the death is assumed to be of natural causes?
A No. Absolutely not.
Q So every death should be considered and go through the mortality review process.
A Yes.
MS. MAKAR: Objection. Form.
THE WITNESS: That's a shocking question.
BY MR. KNOTT:
Q And you agree that -- well, strike that.
I'm going to share the screen and try to -- we prepared a document based on the materials that we received sometime in the afternoon, and I just want to make sure that we have this correct.
And, Doctor, do you have something there that you can look at to tell us that these are, in fact, the records that you received?

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A No. I would -- like I did before, I mean, I could figure this out in short order, but not -- I would need to turn off my camera or somehow disconnect.
Q You can't open a folder and tell us whether the list is the list that you -- of files that you reviewed?
MS. MAKAR: Objection.
THE WITNESS: No. I mean, the way I can -- one way I can do it is I'm going to try and count to see if there's 26 names there, because I know, just from memory, that I got 26 names.
BY MR. KNOTT:
Q Well, I'm --
A I have no way of just sitting here and instantly doing that, no.
Q Okay. And I'll tell you, there are 26 names there and --
A You know what? Some names have been dropped or replaced. I recall affirmatively from my memory, and I'm confident in this, that I received a file that I opened -- or a folder that I opened, whatever term you want to use, and there were 26 files in there, and each were

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kind of alphabetical, and so this looks very much like those 26 to me.
Q And can we assume that you paid careful attention and reviewed very carefully each file that was sent to you?
MS. MAKAR: Objection. Form.
THE WITNESS: Well, some -- as I say, I think, in my report, I go into detail about my process, but some of these files were incomplete or didn't seem to have information that was going to be -- my lens in opening -- I opened every one of these -- was does the information in any of these files reflect the three core findings -- because the fourth is the mortality review -- the three core findings for Ms. Boyer's case.
So my process was to open each of these and then look to see is there anything that indicates the presence of one of these three things.
BY MR. KNOTT:
Q But you would have looked at each file, correct?
A Yes.
Q And there's a few different categories there

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from a different production. There are five files from the Monroe County production. And are you able to confirm that you reviewed the records for each of these patients?
MS. MAKAR: Do you want to mark this as an exhibit, Doug?
MR. KNOTT: I will.
MS. MAKAR: Okay.
THE WITNESS: I don't know. I have to -- I'm looking up that name Rebeles. I don't know if that's -- that doesn't -- I don't see it in the report. So I guess I can. I would certainly be able to take this list that you've just presented me at the end of the deposition and compare it to the files I have on my hard drive, but as I sit here today, I'm not sure I can do that.
BY MR. KNOTT:
Q And do you recognize the names that are listed below under Plaintiff Production?
A I don't really -- I'm not sure I recognize those names. Just the Monroe County I recognize.
Q And my understanding is this came from -- directly from the email we received sometime

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this afternoon of the listing of files reviewed by you.

MR. KNOTT: And so I guess could I ask, Ms. Makar, that you confirm that this list -- I'll mark it -- is in fact the records that were reviewed by Dr. Venters?

MS. MAKAR: Yes.

MR. KNOTT: Okay.

BY MR. KNOTT:

Q And, Dr. Venters, do you have -- if I highlight this Brandon Lessman for an example, do you have the capacity, as you sit there today, to open that file?

A No. It's the same problem when we talked about another patient. I'm pretty confident I recognize that name, I think from the report, but I can't open the medical records as I sit here.

Q And I guess tell me, again, why that is again.

A I have to -- I mean, I could disconnect my camera, and then it's just a US -- the number of USB ports but --

Q I got it. Okay.

I've located the -- I want to work with the exhibit numbers, but I think we can do

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that off the record and have a stipulation that the exhibits that we've reviewed will be marked according to a sequence.

That's all I have for now, Doctor.

THE WITNESS: Thank you.

MR. JONES: I do not have anything more.

MR. CASSERLY: I have no follow-up.

MS. MAKAR: I have one follow-up question, Doctor.

EXAMINATION

BY MS. MAKAR:

Q So now having been asked another set of questions, have any of your opinions in your report changed?

A No.

MS. MAKAR: Thank you.

MR. KNOTT: Okay. Let's go off the record, and if we need to add to the record about the exhibits, we can do that, but --

THE WITNESS: Am I able to leave?

MR. KNOTT: I think we can cut you free.

THE WITNESS: All right. Thank you.

MR. KNOTT: Thanks for your time.

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(Concluded at 3:52 p.m.)

(Exhibits 109 through 116 were submitted electronically to the reporter following the conclusion of the deposition and marked for identification. The original exhibits were attached to original transcript; electronic copies provided with transcript copies.)

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STATE OF WISCONSIN)
) SS
MILWAUKEE COUNTY)

I, JULIE A. POENITSCH, RPR/RDR/CRC, Certified Realtime Reporter, and Notary Public in and for the State of Wisconsin, do hereby certify that the preceding remote Zoom deposition was stenographically reported by me and reduced to writing under my personal direction.

I further certify that said deposition was taken before me, with all parties appearing via Zoom Videoconference, on the 9th day of January, 2025, commencing at 9:02 a.m. and concluding at 3:52 p.m.

I further certify that I am not a relative or employee or attorney or counsel of any of the parties, or a relative or employee of such attorney or counsel, or financially interested directly or indirectly in this action.

In witness whereof, I have hereunto set my hand and affixed my seal of office at Milwaukee, Wisconsin, on this 27th day of January, 2025.

_____
JULIE A. POENITSCH - Notary Public
In and for the State of Wisconsin

My commission expires January 25, 2027.

C

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